ARIZONA MEDICAID
ELECTRONIC HEALTH RECORD
INCENTIVE PROGRAM

ELIGIBLE PROFESSIONAL
MEANINGFUL USE ATTESTATION USER GUIDE

AHCCCS

UPDATED NOVEMBER 2012

Arizona Health Care Cost Containment Center
Our first care is your health care

CONTENTS

Introduction

The Arizona Medicaid Electronic Health Record (EHR) Incentive Program will provide incentive payments to eligible professionals and eligible hospitals as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology. This incentive program is designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care.

The Arizona Health Care Cost Containment System Administration (AHCCCS) is responsible for the implementation of Arizona's Medicaid EHR Incentive Program.

Regional Extension Center (REC) is dedicated to providing assistance to Eligible Professionals (EPs) regarding EHR Incentive Program. To learn more about how the Regional Extension Center can help you, please contact them at:

- Arizona REC: Call 602-688-7200 or Email ehr@azhec.org or Visit www.arizonarec.org.
- National Indian Health Board AI/AN National REC: Visit www.nihb.org/rec/rec.php.

If you have any questions regarding EHR Incentive Program, please contact AHCCCS EHR Incentive Program at:

Help Desk: 602-417-4333

Email: EHRIncentivePayments@azahcccs.gov

Background

The Center for Medicare & Medicaid Services (CMS) has implemented provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111–5) that provide incentive payments to eligible professionals (EPs), eligible hospitals and critical access hospitals (CAHs) participating in Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified electronic health record (EHR) technology.

It's important to know that the EHR Incentive Program is NOT a reimbursement program for purchasing or replacing an EHR. Providers must meet specific requirements in order to receive incentive payments.

The Medicare and Medicaid EHR Incentive Program requires the use of certified EHR technology. Standards, implementation specifications, and certification criteria for EHR technology have been adopted by the Secretary of the Department of Health and Human Services. EHR technology must be tested and certified by an Office of the National Coordinator (ONC) Authorized Testing and Certification Body (ATCB) in order for a provider to qualify for EHR incentive payments. Click here for a List of Certified EHR Technology (CHPL) - Opens in a new window and here HHS Office of National Coordinator Health IT Web Site - Opens in a new window
Note: Even if you are already using EHR technology, it must be tested and certified by an ONC-ATCB specifically for the Medicare and Medicaid EHR Incentive Programs.

EPs are encouraged to check CMS official website for the Medicare and Medicaid EHR Incentive Program regarding path to payment, eligibility, certified EHR technology, meaningful use, clinical quality measures, etc.

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

This User Guide aims to help EPs with Meaningful Use attestation. The step by step guide will help EPs navigate the Attestation module. The user guide page layout consists of the attestation screen and corresponding instructions. Please note, the actual attestation screens may not be exactly the same as those in the User Guide.

Eligibility

Eligible professionals under the Arizona Medicaid EHR Incentive Program include:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Nurse practitioners
- Certified nurse-midwives
- Dentists
- Physician assistants (PA) who furnish services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a physician assistant.

In addition to the above provider eligibility requirement, Physician Assistants (PA) in FQHC/RHC must meet one of the following requirements to quality to participate in the EHR Incentive Program.

- PA is the primary provider in a clinic (Example: part-time physician and full-time PA)
- PA is a clinical or medical director at a clinical site of practice
- PA is an owner of an RHC

Additional Requirements for Eligible Providers (EPs)

To qualify for an EHR incentive payment each year, the EP must meet the Patient Volume criteria, Non-Hospital Based criteria/Practice Predominantly criteria and No Sanction criteria.

Patient Volume Criteria

Arizona Medicaid EPs are required to meet a specific patient volume threshold each payment year to be eligible for the EHR Incentive Program. Patient volume reporting methods include Medicaid Patient Volume Type or Needy Individual Patient Volume Type. EPs in FQHCs/RHCs have a special option of qualifying using either the Medicaid Patient Volume Type or Needy Individual Patient Volume Type. All other EPs must use Medicaid Patient Volume Type. Pediatricians have a special exception in meeting the patient volume.

Medicaid Patient Volume Criteria

For purposes of calculating the Medicaid Patient Volume, Medicaid Patient Encounters are services rendered to an individual on any one day where Medicaid paid for part or all of the service, individual's premiums, copayments and/or cost-sharing.

The Medicaid Patient Volume Threshold percentage is defined as the total Medicaid Patient Encounters in any
representative continuous 90-day period in the preceding year, divided by the total of all patient encounters in the same 90-day period multiplied by 100%.

To qualify for an incentive payment under the Medicaid EHR Incentive Program, an EP selecting Medicaid Patient Volume type must meet **one** of the following criteria:

- Have a minimum 30% Medicaid patient volume*
- Have a minimum 20% Medicaid patient volume, and is a pediatrician**

* Children's Health Insurance Program (CHIP – Title XXI) patients do not count toward the Medicaid patient volume criteria.

****** Pediatricians have a special exception to satisfy either:

- a minimum 20% patient volume but receives for 2/3 of the EHR Incentive Program payment or
- a minimum 30% patient volume for the full EHR Incentive Program payment

Needy Individual Patient Volume Criteria

For purposes of calculating the Needy Individual Patient Volume, Needy Individual Patient Encounters are services rendered to an individual on any one day to where Medicaid or Children's Health Insurance Program (CHIP) paid for part or all of the service, individual's premiums, co-payments, and/or cost sharing; or Services rendered to an individual on any one day on a sliding scale or that were uncompensated.

The Needy Individual Patient Volume Threshold percentage is defined as the total Needy Individual Patient Encounters in any representative continuous 90-day period in the preceding year, divided by the total of all patient encounters in the same 90-day period multiplied by 100.

To qualify for an incentive payment under the Medicaid EHR Incentive Program, an EP selecting Needy Individual Patient Volume type must meet **one** of the following criteria:

- Have a minimum 30% Needy Individual patient volume*
- Have a minimum 20% Needy Individual patient volume, and is a pediatrician.

* Needy Individual Patient Volume is the percentage of Medicaid Title XIX, CHIP Title XXI and 'Patients Paying Below Cost' Patient Encounters. Only EPs in a FQHC/RHC can select this option. Providers selecting this option must satisfy the requirement in the **Eligibility** section.

Qualifying Providers by Type and Patient Volume

Entity	Minimum 90-day Medicaid Patient Volume Threshold	Minimum 90-day Needy Individual Patient Volume Threshold
Physicians	30%	30%
Pediatricians	30% or optional 20%	30% or optional 20%
Dentists	30%	30%
Certified Nurse Midwives	30%	30%
Physician Assistants when practicing at an FQRC/RHC led by a Physician Assistant	30%	30%
Nurse Practitioner	30%	30%

Group Practices or Clinics

EPs in a Group Practice or Clinic, referred to below as 'Practice', who uses the Practice's data, must decide if each provider will use the EP's Individual Patient Volume or the Practice's Aggregate Patient Volume Methodology.

If using the Individual Patient Volume Methodology, data is based on the sum of patient encounters for a single EP.

If using the Aggregate Patient Volume Methodology, data is based on the sum of patient encounters for the entire Practice (includes multiple providers) but can only be used as a proxy for all EPs in the Practice if all of the below Federal and State Specific Rules are met:

Aggregate Patient Volume Methodology Conditions

Aggregate Patient Volume Methodology Conditions	
Federal Specific Rules	**State Specific Rules**
1. Practice's patient volume is appropriate as a patient volume methodology calculation for the EP (i.e. if an EP only sees Medicare, commercial or self-pay patients, this is not an appropriate calculation)	1. All EPs in the practice must use the same aggregate patient volume data for the payment year
2. There is an auditable data source to support the Practice's patient volume determination	2. EPs employed during the payment year are permitted to use the Practice's aggregate patient volume data if meeting the Federal Specific Rules. In the event of an audit, the Practice and the EP must successfully demonstrate these EPs have satisfied these requirements during the payment year
3. All of the EPs in the Practice must use the same methodology for the payment year	
4. The Practice uses the entire Practice's patient volume and does not limit patient volume in any way	
5. If EP works both inside & outside of the Practice, then the patient volume calculation includes only those encounters associated with the Practice and not the EP's outside encounters	

On behalf of the Practice, the Office Manager/Administrator must contact AHCCCS to establish the Practice in the ePIP System and provide the following information before an EP can begin attestation in ePIP:

- Letterhead with Practice's AHCCCS Provider Number, EHR Certification Number, Patient Volume Methodology, if applicable, Aggregate Medicaid Patient Encounters, Aggregate Total Patient Encounters
- List of each provider within the Practice showing name, AHCCCS provider number, Provider Type, Physician Type & PA Led Type (Excel)

Note: EP can only use Practice data to report Medicaid Patient Volume or Needy Individual Patient Volume.

Out of state encounters

Eligible Providers have the option to include out-of-state patient encounters in their eligible patient volume threshold. If electing to do so, they must report each state's Medicaid encounters separately. This will trigger an eligibility verification audit and require AHCCCS to contact the other state(s) to confirm patient encounter data. This will delay payment until the data is properly validated.

Non-Hospital Based Criteria (apply to EP selecting Medicaid Patient Volume Type only)

EPs selecting the Medicaid Patient Volume Type cannot be hospital-based. EP's patient encounters will be evaluated to determine if rendered services in a hospital-based place of service exceeds the 90% threshold.

Hospital-Based Patient Encounters are encounters received at an inpatient hospital place of service and/or at an emergency department place of service.

This criterion is Not applicable to FQHC/RHC EPs utilizing the Needy Individual Patient Volume Criteria.

Note: EP may not use Practice data to report Hospital-Based data

Practice Predominantly Criteria (apply to EP selecting Needy Individual Patient Volume Type only)

EPs selecting the Needy Individual Patient Volume Type must demonstrate that they practice predominantly at FQHC/RHC facilities. EPs in a FQHC/RHC not practicing more than 50% at FQHC/RHC Facilities are not eligible for the Medicaid EHR Incentive Program

Note: EP may not use Practice data to report Practice Predominant data.

No-Sanction Criteria

Eligible Providers must have the proper licenses/certifications and not have active unresolved sanctions. AHCCCS will use existing operational protocols to validate licensure and sanctions.

Eligible Providers must meet licensure/certification requirements applicable to its provider type as required by the professional licensing and certification boards or entities and as specified by federal and state statutes and regulations.

Eligible Providers may be sanctioned by AHCCCS for violations of the terms of the AHCCCS Provider Agreement. Sanctions may be imposed due to fraudulent or abusive conduct on the part of the AHCCCS provider. Sanctions must be resolved before disbursement of the EHR Incentive Program payment.

MEANINGFUL USE REQUIREMENTS

Meaningful Use General Requirements

For providers who work at multiple practice locations, at least 50% of all their encounters must take place at a location(s) with CEHRT system.

Note: For the purpose of calculating this 50 percent threshold, any encounter where a medical treatment is provided and/or evaluation and management services are provided should be considered a "patient encounter."

At least 80% of unique patients seen at location(s) with CEHRT system must have their data in a certified EHR technology (CEHRT) system during the EHR reporting period.

Meaningful Use Measures Requirements

- **Core Measure**: 15 out of 15 Core Measures must be met according to CMS threshold. If an EP meets the criteria for and can claim exclusion for measures that apply, then the measure(s) is also considered met.

- **Menu Measure**: 5 out of 10 Menu Measures must be met according to CMS threshold and at least 1 of the 5 Menu Measures met by the EP must be from the Public Health List. Currently in Arizona, the only Public Health measure can be accepted is Immunization Registry which is available through the Arizona State Immunization Information System (ASIIS). If an EP meets the criteria for and can claim exclusion for measures that apply, then the measure(s) is also considered met.

- **Clinical Quality Measure**: 3 Core Clinical Quality Measures (CQM) and/or up to 3 Alternate CQMs (If an EP reports a denominator of 0 for any of the 3 Core CQMs, the EP must report for an Alternate Core CQM to supplement the Core CQM) and 3 Additional CQMs that relate to their practice (the EP must select 3 out of 38 Additional CQMs provided). Zero is an acceptable CQM denominator value provided that this value was produced by certified EHR technology.

Note: All measures are limited to actions taken at practices/locations equipped with certified EHR technology.

Incentive Payment

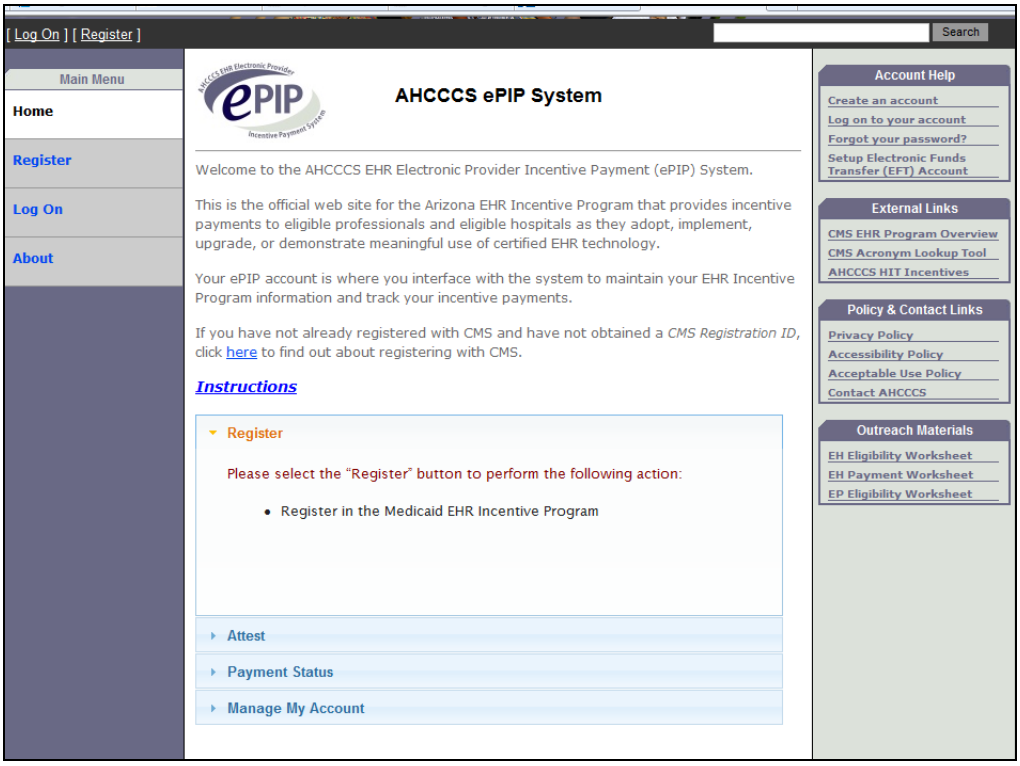
The maximum incentive payment an EP could receive from Arizona Medicaid EHR Incentive Program equals $63,750 over a six years period, or $42,500 for pediatricians with more than 20% but less than 30% patient volume as shown below.

Payment Year	Attestation For	EP Payment Amount	
		EP 30% PV; Pediatrician 30% PV	Pediatrician 20% PV
Year 1	AIU	$21,250	$14,167
Year 2	MU	$8,500	$5,667
Year 3	MU	$8,500	$5,667
Year 4	MU	$8,500	$5,667
Year 5	MU	$8,500	$5,667
Year 6	MU	$8,500	$5,667

EP payments will be made based on Calendar Year (CY) data and an EP must begin receiving incentive payments no later than CY 2016 to participate in the Program. EPs will assign the incentive payments to a tax ID (TIN) in the CMS EHR Registration and Attestation National Level Repository (NLR). The TIN must be associated in the Arizona PMMIS system with either the EP him/herself or a group or clinic with whom the EP is affiliated. Arizona Medicaid EPs are not required to participate on a consecutive annual basis, however, the last year an EP may begin receiving payments is 2016, and the last year the EP can receive payments is 2021. EP & Payee must have an active Electronic Funds Transfer (EFT) record with AHCCCS in order to receive payments. There are no payment adjustments or penalties for Medicaid Eligible Providers.

Payments may be recouped in cases of fraud, abuse or if AHCCCS' audit determines the provider was ineligible for the EHR Incentive Program Payment.

Getting Started - Welcome Page

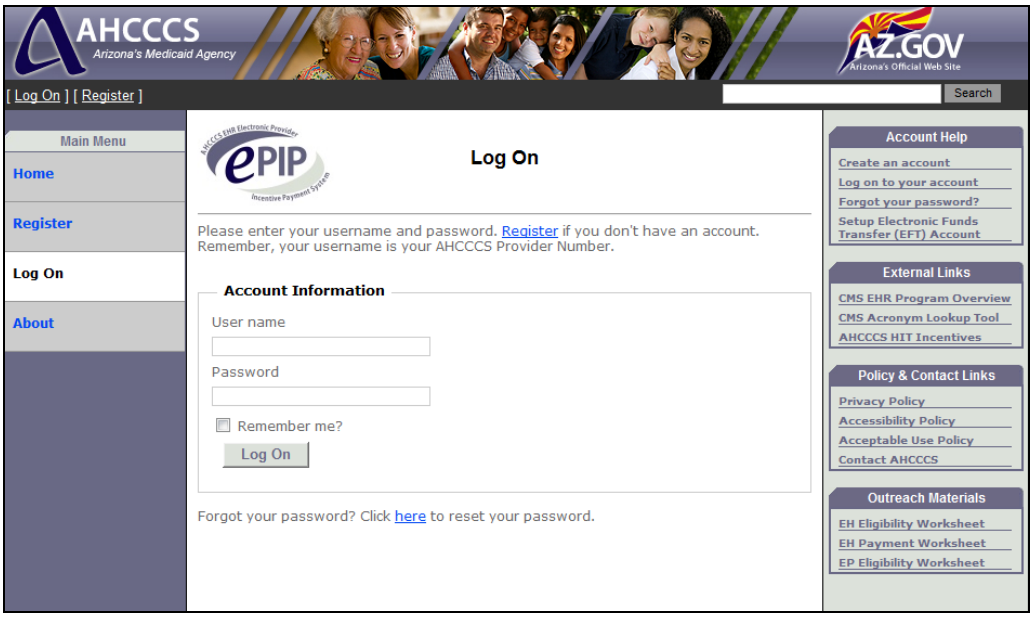


EPs will need to attest Arizona Medicaid EHR Incentive Program Meaningful Use through AHCCCS ePIP system.

Access the portal at: https://www.azepip.gov/ or via the AHCCCS public website: http://www.azahcccs.gov/.

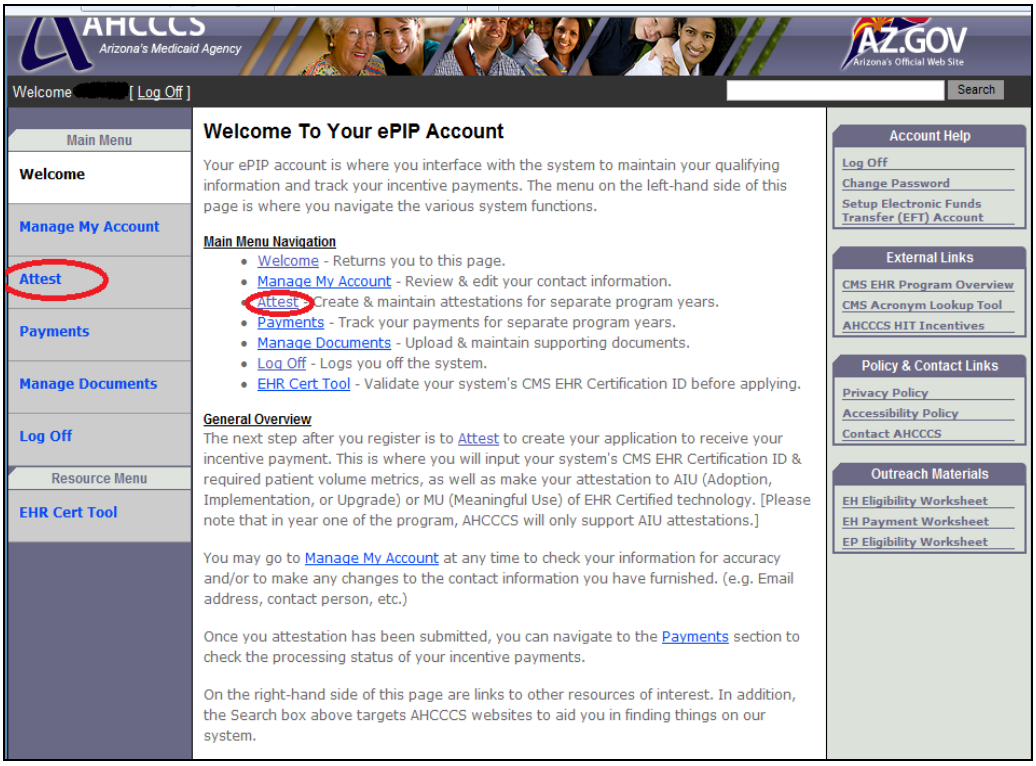
Click **EHR Incentive Program**, then click the ePIP logo.

Log On Screen



EPs will need to enter their User Name (*AHCCCS provider number*) and Password to log on.

Welcome To Your ePIP Account



After logging on the system, the User can also choose from the following actions:

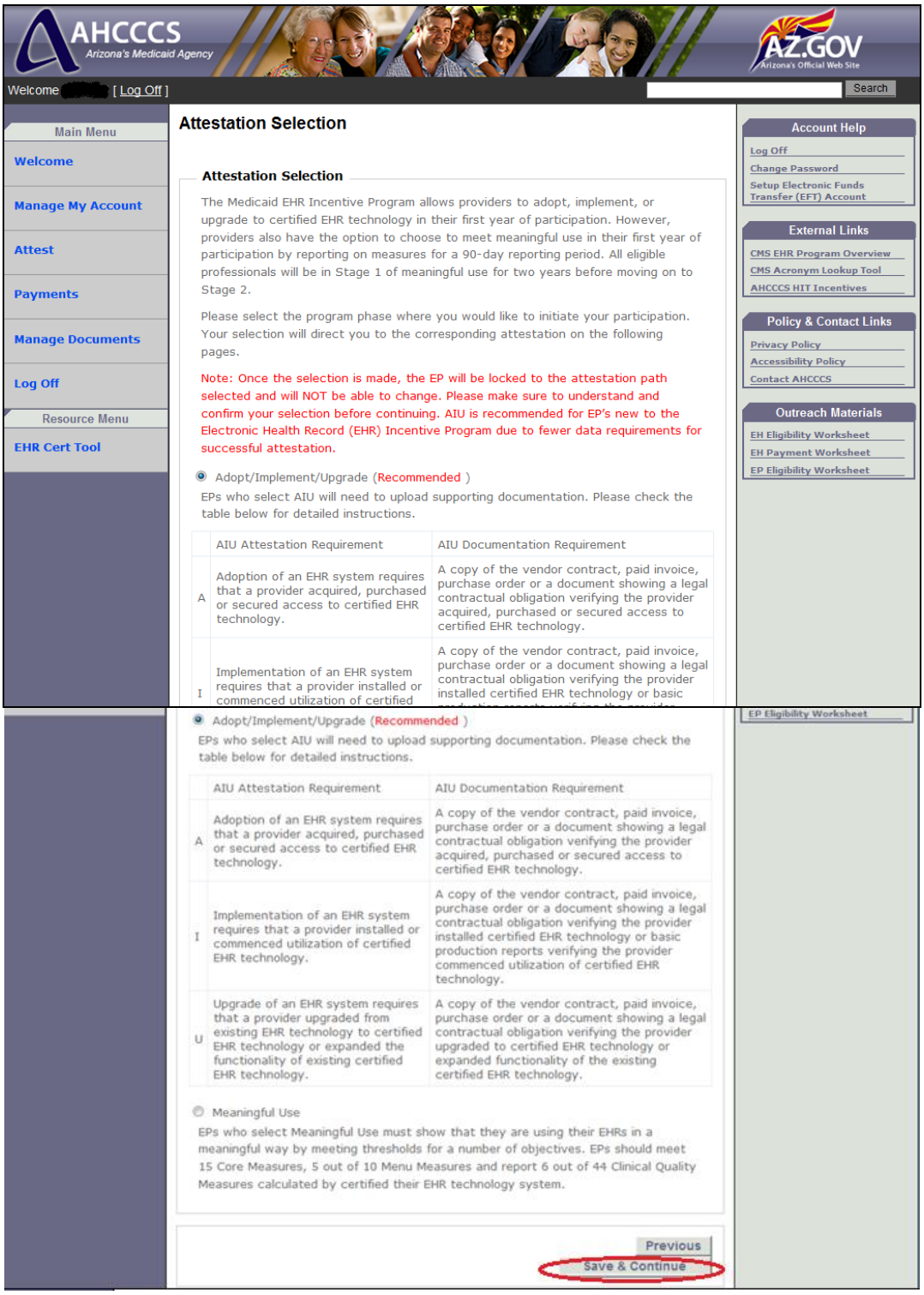
- **Welcome** - Returns you to this page.
- **Manage My Account** - Review & edit your contact information.
- **Attest** - Create & maintain attestations for separate program years.
- **Payments** - Track your payments for separate program years.
- **Manage Documents** - Upload & maintain supporting documents.
- **Log Off** - Logs you off the system.
- **EHR Cert Tool** - Validate your system's CMS EHR Certification ID before applying.

Click "**Attest**" to start attestation.

First Year EPs- Attest

Click "**Create New**" to start an Attestation.

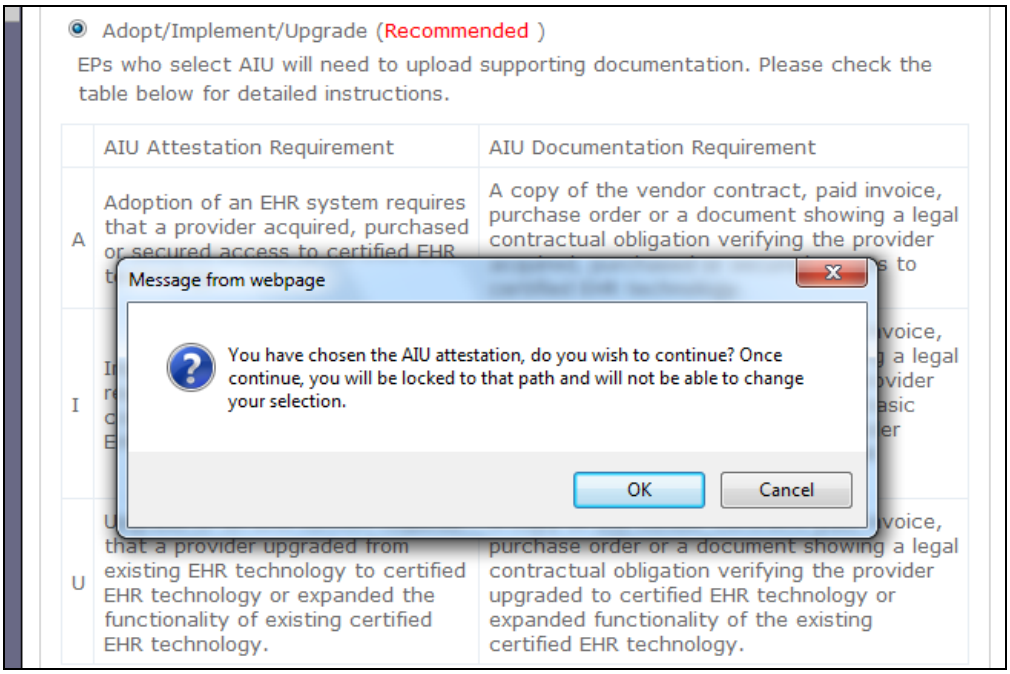
First Year EP - Attestation Selection



First Year EPs can select AIU attestation or MU attestation.

NOTE: Adopt, Implement, and Upgrade (AIU) is **highly recommended** for EPs new to the EHR Incentive Program due to fewer data requirements for successful attestation.

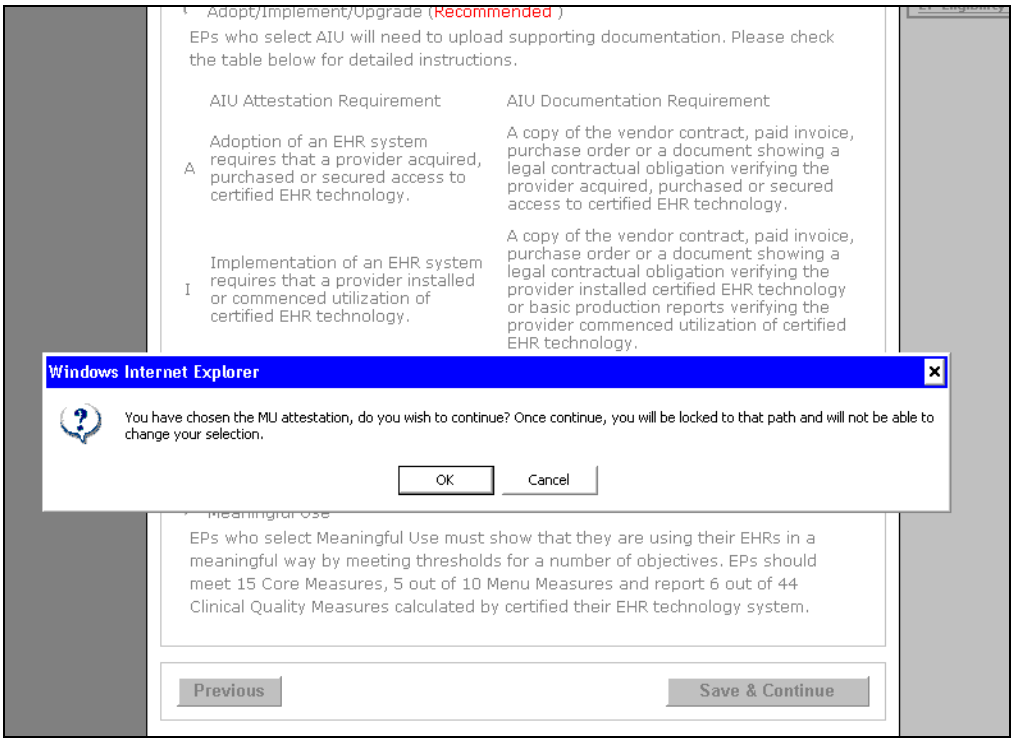
First Year EP- AIU Selected 1



Click "**OK**" to confirm and continue with the attestation selected. EPs will be locked to that path and will not be able to change the selection. EPs can contact EHR Incentive Program staff to unlock the path if a wrong selection was made.

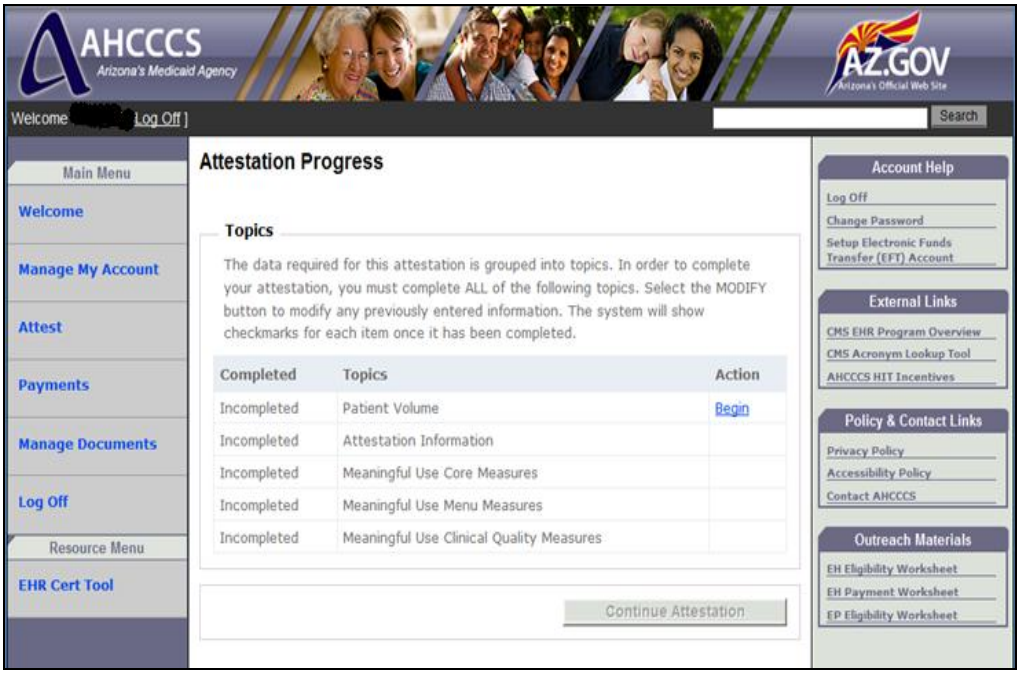
Please refer to the AIU User Manual for instructions on how to proceed through the system. The AIU User Guide can be found at: **http://www.azahcccs.gov/HIT/downloads/EP_Reference_Guide.pdf.**

First Year EP- MU Selected 1



Click "**OK**" to confirm and continue with the attestation selected. EPs will be locked to that path and will not be able to change the selection. EPs can contact EHR Incentive Program staff to unlock the path if a wrong selection was made.

First Year EP- MU selected 2 (MU Attestation Progress)

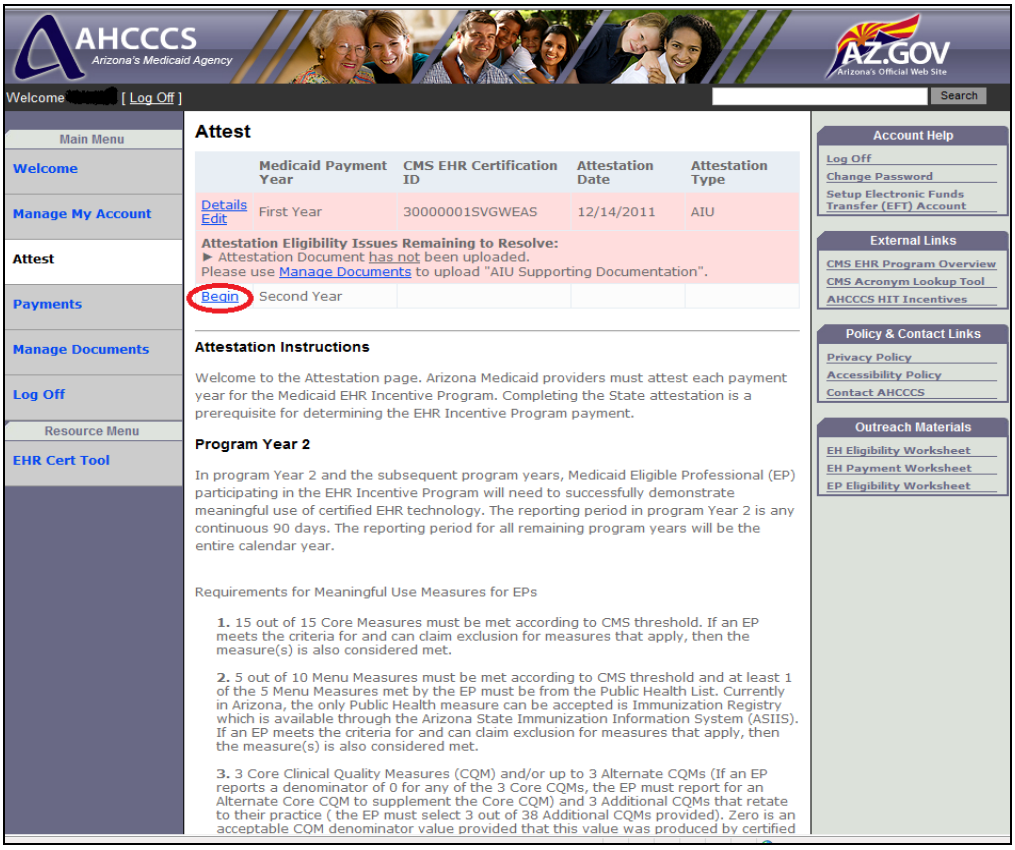


EPs need to attest the following topics: Patient Volume, Attestation Information, Meaningful Use Core Measures, Meaningful Use Menu Measures and Meaningful Use Clinical Quality Measures.

EPs need to start with the first topic (Patient Volume), then the second topic (Attestation Information). Once criteria for both topics are met, the EP can continue with Meaningful Use Measures (no sequence required). If the EP cannot meet Patient Volume and Attestation Information criterion, the EP will be disabled from continuing with the Meaningful Use Measures.

Please click "**Begin**" to start Patient Volume.

Second Year EP - Attest

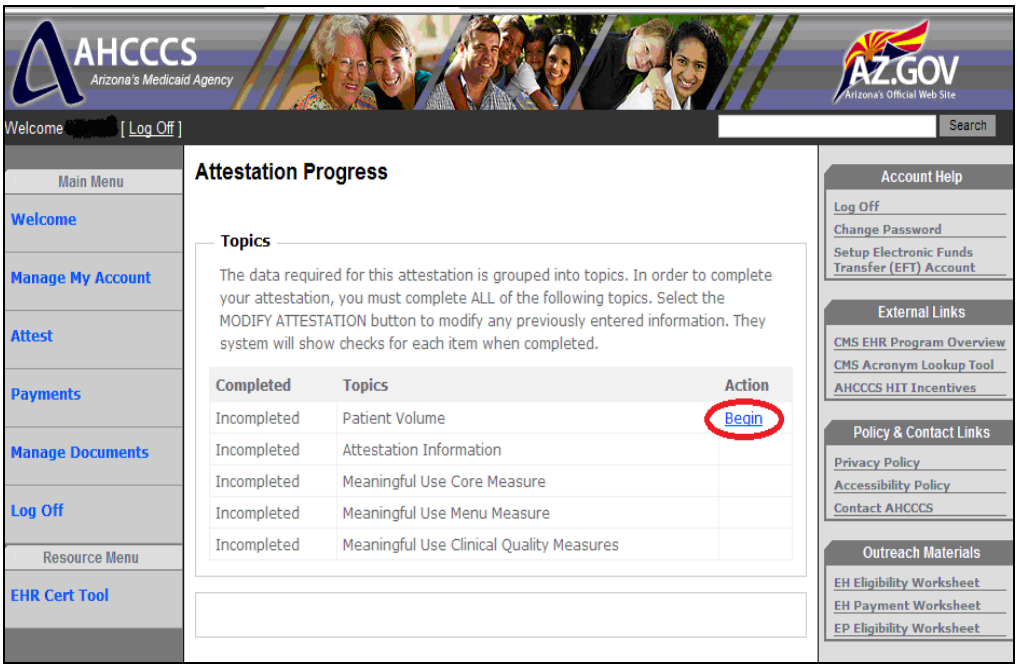


All EPs who have successfully attested AIU can view the detail information by clicking "Details" for the first payment year. To Begin MU Attestation (program year 2), Click "**Begin**".

Depending on the current status of your attestation, EPs can select one of the following actions:

- **Begin**: Begin Meaningful Use Attestation
- **Edit**: Edit a previously started Meaningful Use Attestation that has not yet been submitted.
- **Resubmi**t: Resubmit a failed or rejected attestation
- **Detail**: View details on a Meaningful Use Attestation that has been submitted and accepted.

Attestation Progress



EPs need to attest the following topics: Patient Volume, Attestation Information, Meaningful Use Core Measures, Meaningful Use Menu Measures and Meaningful Use Clinical Quality Measures.

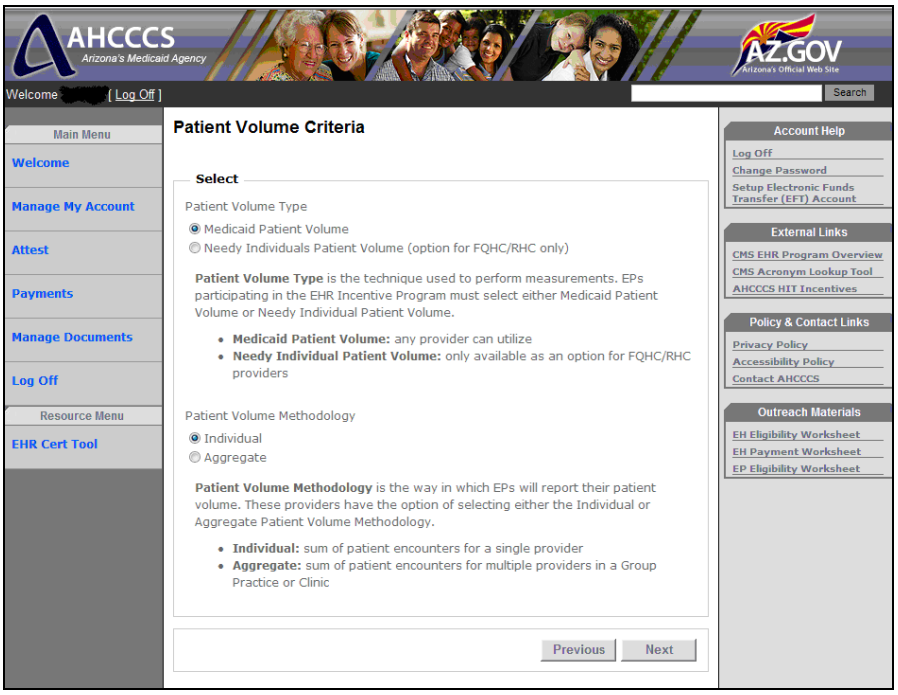
EPs need to start with the first topic (Patient Volume), then the second topic (Attestation Information). Once criteria for both topics are met, the EP can continue with Meaningful Use Measures (no sequence required). If the EP cannot meet Patient Volume and Attestation Information criterion, the EP will be disabled from continuing with the Meaningful Use Measures.

Please click "**Begin**" to start Patient Volume.

PATIENT VOLUME SELECTION SCREENS

Patient Volume Information - Scenario 1

Type = Medicaid Patient Volume
Methodology = Individual



General Patient Volume Instructions:
Please select Patient Volume Type: Medicaid Patient Volume or Needy Individuals.

Note: Only FQHC/RHC providers can select Needy Individual Patient Volume; all other providers must select Medicaid Patient Volume.

Please select Patient Volume Methodology: Individual or Aggregate.

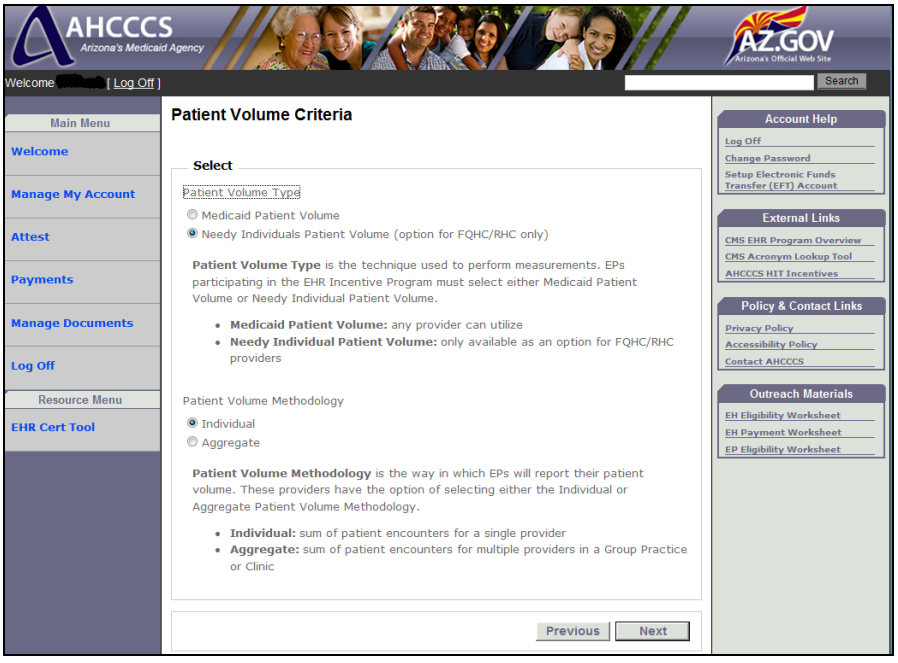
Note: Patient Volume Methodology is the way in which EPs will report their patient volume. These providers have the option of selecting either the Individual or Aggregate Patient Volume Methodology.

- Individual: sum of patient encounters for a single provider.
- Aggregate: sum of patient encounters for multiple providers in a Group Practice or Clinic.

Click "**Next**" to save and go to Medicaid Patient Volume page or click "**Previous**" to go back to Attestation Progress.

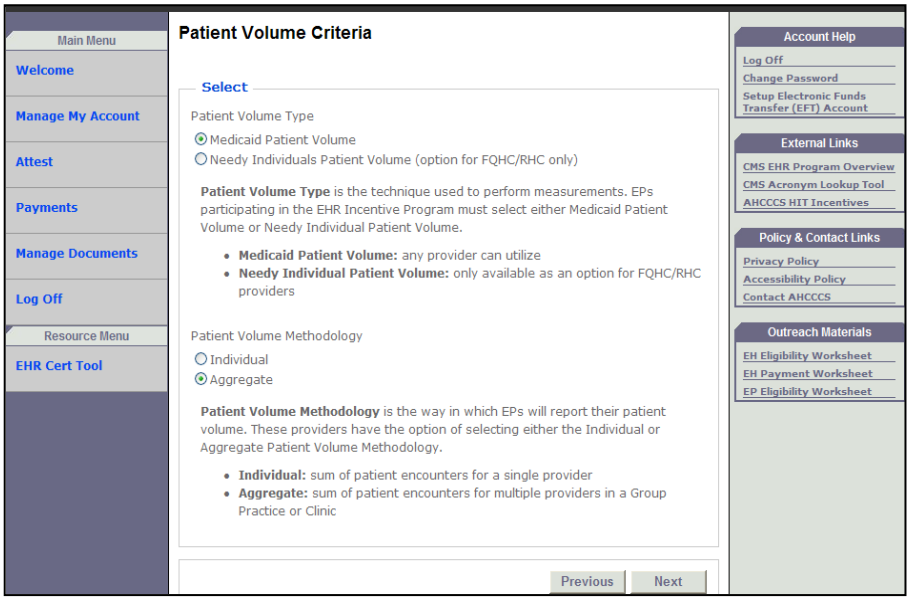
Patient Volume Information - Scenario 2

Type = Needy Individuals Patient Volume;
Methodology = Individual



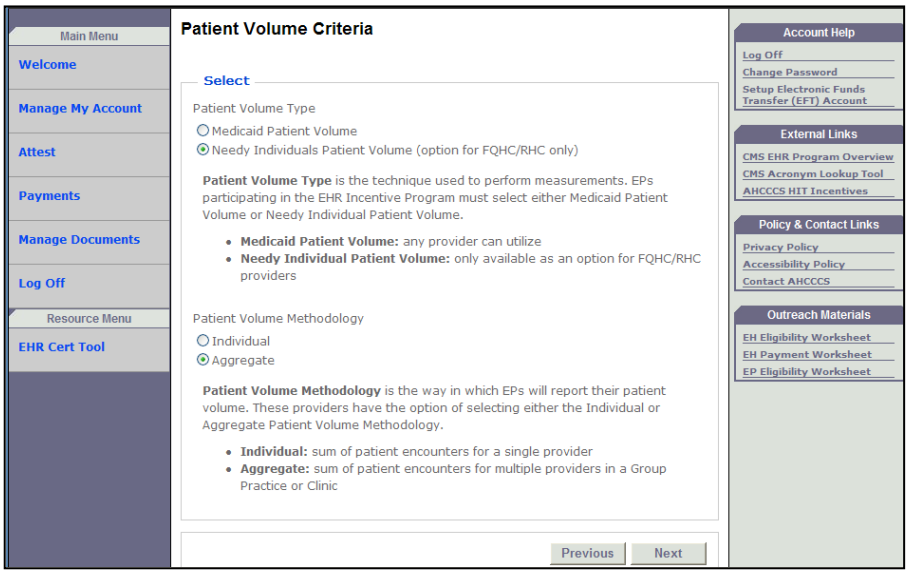
Patient Volume Information - Scenario 3

Type = Medicaid Patient Volume
Methodology = Aggregate



Patient Volume Information - Scenario 4

Type = Needy Individuals Patient Volume;
Methodology = Aggregate



Aggregate Patient Volume Information:

EPs in a Group Practice or Clinic, referred to below as 'Practice', who uses the Practice's data, must decide if each provider will use the EP's Individual Patient Volume or the Practice's Aggregate Patient Volume Methodology.

If using the Aggregate Patient Volume Methodology, data is based on the sum of patient encounters for the entire Practice (includes multiple providers) but can only be used as a proxy for all EPs in the Practice if all of the Federal & State Specific Rules on the following page) are met.

On behalf of the Practice, the Office Manager/Administrator must contact AHCCCS to **establish** the Practice in the ePIP System and provide the following information before an EP can begin attestation in ePIP:

- Letterhead with Practice's AHCCCS Provider Number, EHR Certification Number, Patient Volume Methodology, if applicable, Aggregate Medicaid Patient Encounters, Aggregate Total Patient Encounters
- List of each provider within the Practice showing name, AHCCCS provider number, Provider Type, Physician Type & PA Led Type (Excel)

Once the above procedure is finished, AHCCCS EHR Incentive Program staff will validate the data provided and enter to ePIP system if the validation is passed. The EP can then log on to the ePIP system and start attestation.

Failure to perform the above procedures will prevent an EP from completing attestation, cause submission of an incorrect attestation, delay payment, disbursement of an incorrect payment or denial of payment.

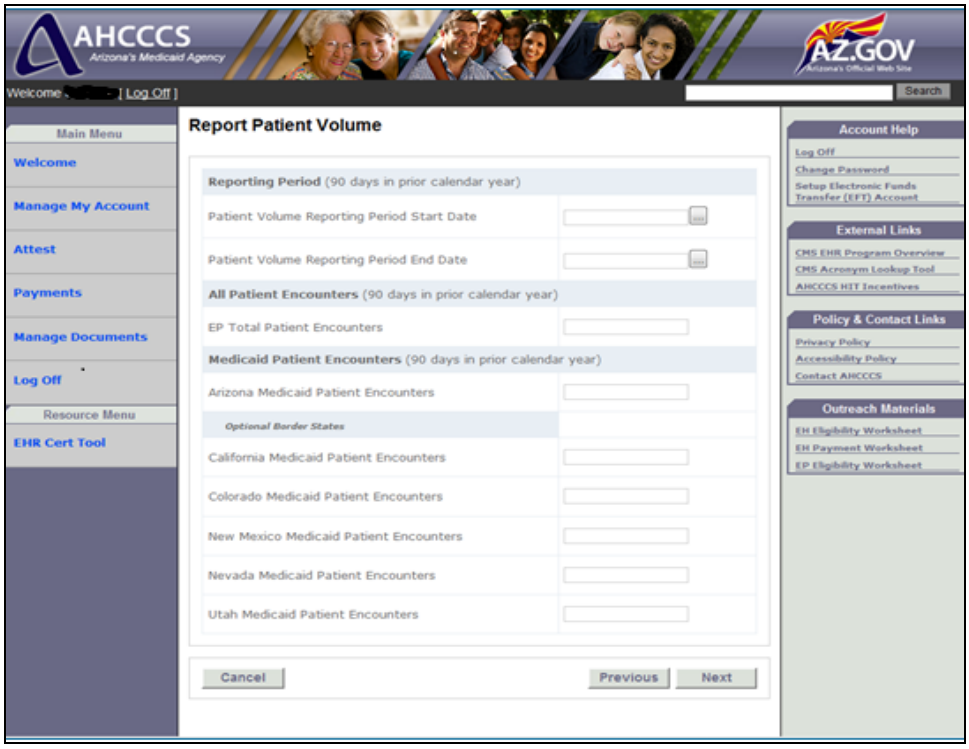
Note: Patient volume screens will be skipped for EPs using "aggregate" methodology.

Aggregate Patient Volume Methodology Conditions

Federal Specific Rules	State Specific Rules
1. Practice's patient volume is appropriate as a patient volume methodology calculation for the EP (i.e. if an EP only sees Medicare, commercial or self-pay patients, this is not an appropriate calculation).	1. All EPs in the practice must use the same aggregate patient volume data for the payment year.
2. There is an auditable data source to support the Practice's patient volume determination.	2. EPs employed during the payment year are permitted to use the Practice's aggregate patient volume data if meeting the Federal Specific Rules. In the event of an audit, the Practice and the EP must successfully demonstrate these EPs have satisfied these requirements during the payment year.
3. All of the EPs in the Practice must use the same methodology for the payment year.	
4. The Practice uses the entire Practice's patient volume and does not limit patient volume in any way.	
5. If EP works both inside & outside of the Practice, then the patient volume calculation includes only those encounters associated with the Practice and not the EP's outside encounters.	

PATIENT VOLUME REPORT SCREENS

Medicaid Patient Volume



- **Patient Volume Reporting Period Start Date**: Please enter the start date of the 90-day period from prior year of the participating program year. (e.g.If your participating program year is 2012, select the patient volume reporting period from 2011).

- **Patient Volume Reporting Period End Date**: Please enter the end date of the 90-day period. Please make sure the date you entered is exactly 90-day, or you will receive an error message indicating you must change the date.

- **EP Total Patient Encounters**: Enter the total number of patient encounters during this reporting period.

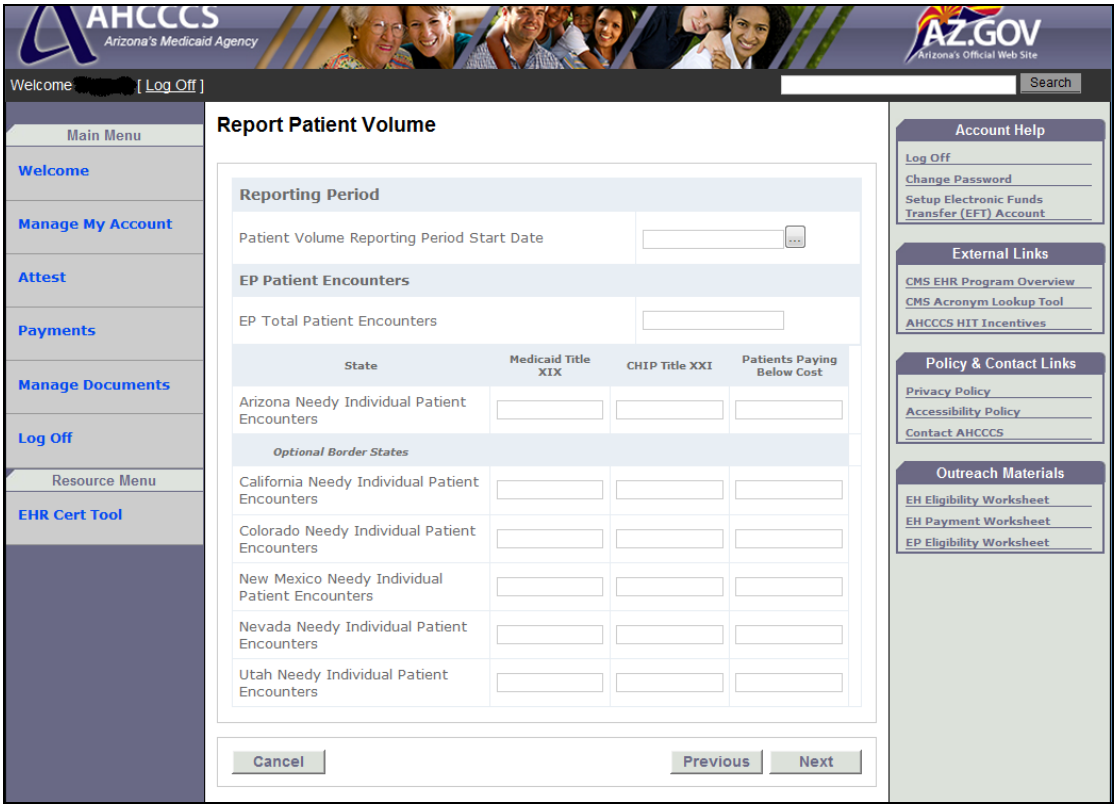
- **Arizona Medicaid Patient Encounters**: Enter total number of Arizona Medicaid Patient Encounters during this reporting period.

- **Optional Border State:** Eligible Providers have the option to include out-of-state patient encounters in their eligible patient volume threshold.
- Note: If electing to do so, EPs must report each state's Medicaid encounters separately. This will trigger an eligibility verification audit and require AHCCCS to contact the other state(s) to confirm patient encounter data. This will delay payment until the data is properly validated.

- **Medicaid Patient Volume Percentage Calculation: (**Medicaid Patient Encounter Volume/Total Patient Encounter Volume)*100%. This percentage must be greater than or equal to 30% to meet the Medicaid patient volume requirement. For Pediatricians, the percentage must be greater than or equal to 20% to meet the Medicaid patient volume requirement.

Click "**Next"** to proceed or "**Previous"** to go to previous page. Click "**Cancel"** to go back to Attest page.

Needy Patient Volume



- **Patient Volume Reporting Period Start Date**: Please enter the start date of the 90-day period from prior year of the participating program year. (e.g. if your participating program year is 2012, select the patient volume reporting period from 2011).

- **EP Total Patient Encounters**: Enter the total number of patient encounters during this reporting period.

- **Arizona Needy Individual Patient Encounters**
  - **Medicaid Title XIX:** The number of Unique Medicaid Title XIX Patient Encounters.
  - **CHIP Title XXI:** The number of Unique CHIP TITLE XXI Patient Encounters
  - **Patients Paying Below Cost**: The number of Unique 'Patients Paying Below Cost' Patient Encounters

- **Optional Border State:** Eligible Providers have the option to include out-of-state patient encounters in their eligible patient volume threshold.

  Note: If electing to do so, EPs must report each state's Medicaid encounters separately. This will trigger an eligibility verification audit and require AHCCCS to contact the other state(s) to confirm patient encounter data. This will delay payment until the data is properly validated.

The Needy Individual Patient Volume Percentage Calculation: Total number of Needy Individual Patient Encounters divided by the total of all patient encounters in the selected 90-day period multiplied by 100%. This percentage must be greater than or equal to 30% to meet the needy individual patient volume requirement.

HOSPITAL-BASED PATIENT ENCOUNTERS REPORT SCREEN (Medicaid)

- **Enter Hospital-Based Reporting Period**: 12 months in prior Calendar Year.

- **Enter EP Total Medicaid Patient Encounters**: The number of All Medicaid Patient Encounters during the reporting period.

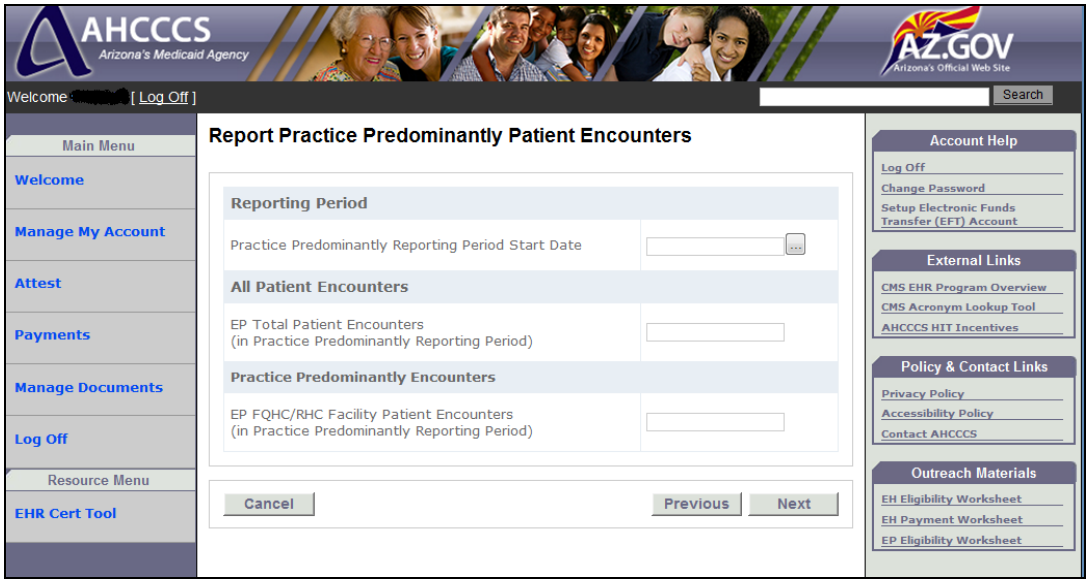
- **Medicaid Hospital-Based Encounters**
- **EP Medicaid Inpatient Hospital Patient Encounters:** The number of All Medicaid Inpatient Hospital Patient Encounters during the reporting period.

- **EP Medicaid Emergency Department Patient Encounters:** The number of All Medicaid Emergency Department Patient Encounters during the reporting period.

Hospital-Based Percentage Calculation: (Medicaid Hospital-Based Patient Encounters/All Medicaid Patient Encounters)*100%. This percentage must be less than 90% to meet the Non-Hospital Based requirement.

Click "**Next"** to save and proceed or "**Previous"** to go previous page. Click "**Cancel"** to go back to Attest page.

PRACTICE PREDOMINANTLY PATIENT ENCOUNTERS REPORT SCREEN (Needy Patient)



- **Practice Predominantly Reporting Period Start Date**: A 6-month Period in the Prior Calendar Year.
- **EP Total Patient Encounters:** Number of All Total Patient Encounters during Practice Predominantly Reporting Period.
- **EP FQHC/RHC Facility Patient Encounters:** Number of Needy Individual Patient Encounters during Practice Predominantly Reporting Period.

Note: EPs may not use Practice data to report Practice Predominant data.

PROVIDER ELIGIBILITY RESULTS SCREENS

Medicaid Provider Eligibility Results

General Eligibility Results Information:

EPs can check Eligibility results in this page.

The qualifying patient volume thresholds for the Medicaid EHR Incentive Program are shown below:

Entity	Minimum 90-day Needy Individual Patient Volume Threshold
Physicians	30%
Pediatricians	30% or optional 20%
Dentists	30%
Certified nurse Midwives	30%
Physician Assistants when practicing at an FQRC/RHC led by a Physician Assistant	30%
Nurse Practitioner	30%

Needy Patient Provider Eligibility Results

Medicaid EPs with 90% or more of their patient encounters in a hospital-based place of service are not eligible for the Medicaid EHR Incentive Program.

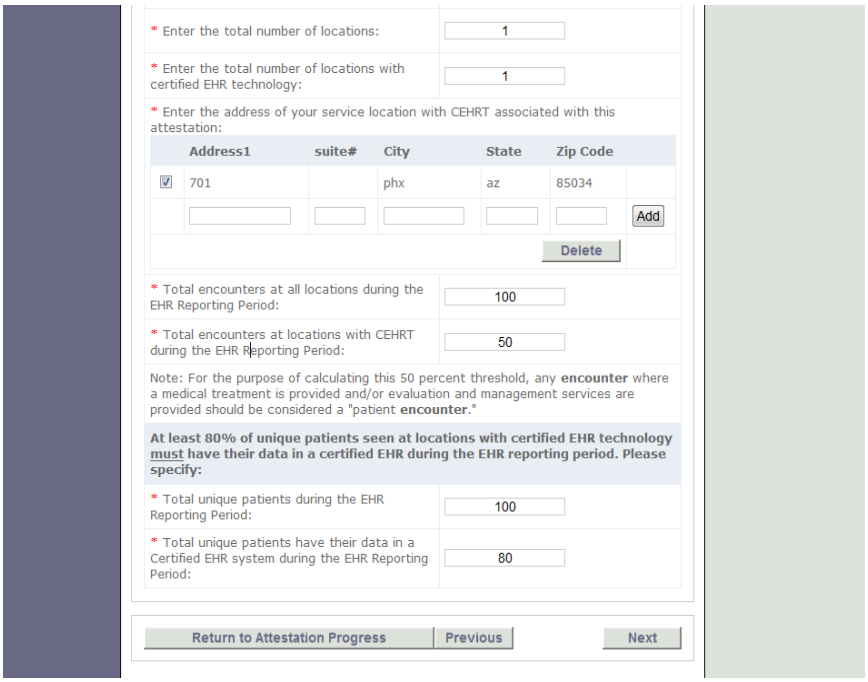
EPs in a ***FQHC/RHC*** not practicing more than 50% at FQHC/RHC Facilities are not eligible for the Medicaid EHR Incentive Program.

If all criterion is met, the EP can check results and click "**Save & Continue"** to move to the MU Attestation Information Page.

If any of the criteria is not met, the EP is not allowed to continue to the next page.

Click **"Previous"** to go previous page.
Click "**Cancel"** to go back to Attest page.

ATTESTATION INFORMATION SCREEN



EPs should meet the criteria (outlined on the right side of this page) before they can continue with MU attestation.

NOTE: Clicking the "**NEXT"** button will validate the data and present any errors. The user must enter all required fields. If no errors, the data is saved and the user is navigated to the Attestation Confirmation page. Clicking the "**Previous"** button will navigate the user to the Provider Eligibility Result Page without saving the data. Clicking the "**Return to Attestation Progress"** button will navigate the user to the Attestation Progress Page without saving the data.

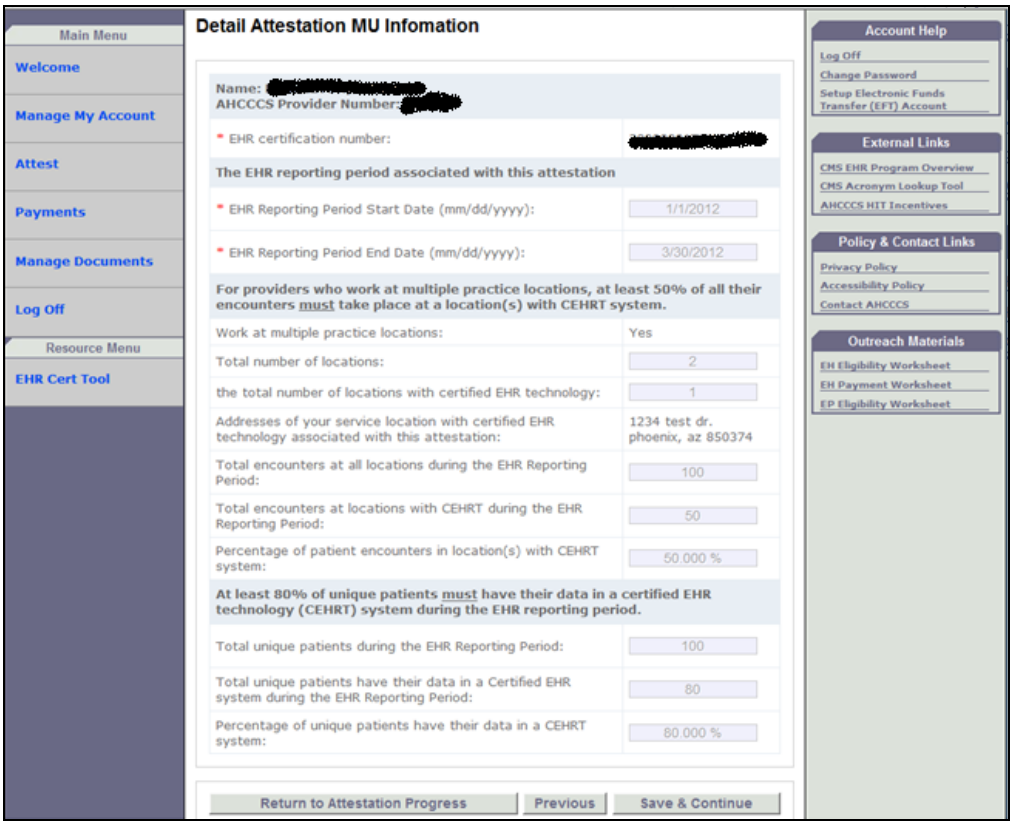
All the fields with red asterisk (*) are required to continue with the attestation:

- **EHR Reporting Period Start Date** – This is the starting date for the period of time you are reporting your Meaningful Use Measure data.
- **EHR Reporting Period End Date** – This is the end date for the period of time you are reporting your Meaningful Use Measure data. Note: The reporting period of first year Meaningful Use is any continuous 90 days within the program year being attested. For the second year of reporting Meaningful Use, an entire year of reporting will be required.
- **Do you work at multiple practice locations** – Indicate if you work at multiple service locations.

  Note: If you answer yes, enter the total number of locations that you work and then enter how many of the locations have certified EHR Technology.
- **Indicate the service location that has certified EHR technology** – Enter the address a service location in which you work that is using certified EHR technology.
- **Enter the total encounters at all locations during the EHR Reporting Period and total encounters at locations with Certified EHR Technology during the EHR Reporting Period** - For providers who work at multiple practice locations, at least 50% of all their encounters must take place at a location(s) with CEHRT system.

  Note: For the purpose of calculating this 50 percent threshold, any **encounter** where a medical treatment is provided and/or evaluation and management services are provided should be considered a "patient **encounter**."
- **Based on the locations with CEHRT system, enter the total unique patients you have seen during the EHR Reporting Period and total unique patients in a certified EHR system during the EHR Reporting Period** - This should be the percentage of all the patients you have seen total who have data recorded in your EHR. The amount of unique patients with structured data stored in your EHR should be at least 80%.

Meaningful Use Attestation Information Confirmation



EPs can check the data they entered for attestation information.

NOTE: Clicking the "**Save and Continue"** button navigates the user to the Meaningful Use Core Measure 1 page.

Clicking the "**Previous"** button will navigate the user to the Meaningful Use Attestation Information page.

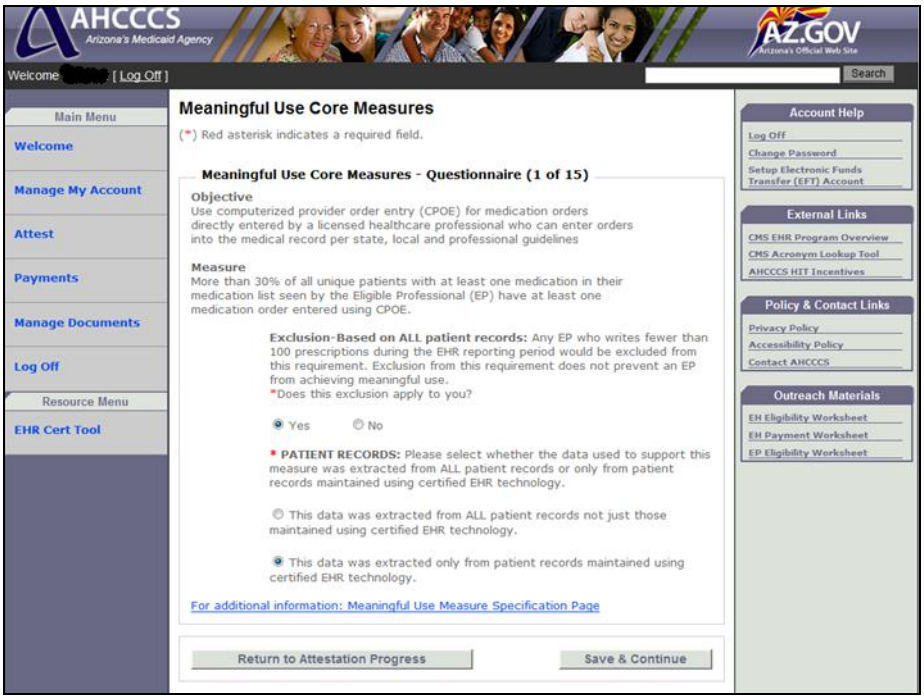
Clicking the "**Return to Attestation Progress"** button will navigate the user to the Attestation Progress Page.

MEANINGFUL USE CORE MEASURES

General Information Related to Core Measures

- The user is required to enter a numerator and denominator or answer Yes/No for each measure unless the user can claim an exclusion.
    - If the user selects "Yes" for an Exclusion, all other fields will be hidden.
- The user must enter all required fields as indicated by the red asterisks.
- The denominator must be >= numerator and exclusions; all data must be non-negative whole numbers.
- Clicking the "**Save & Continue**" button on each screen will validate the data and present any errors.
    - Potential error messages for each screen are described for reference.
- If the system does not determine any errors, the data is saved and the user is navigated to the next Core Measure page.
- Clicking the "**Previous Page"** button will navigate the user to the previous Core Measure Page.
- Clicking the "**Return to Attestation Progress"** button will navigate the user to the Attestation Progress Page.
- Click **"For detailed information about this measure, please click here"** link for the specific requirements and related definitions for each measure.

Core Measure 1 of 15: CPOE for Medication Orders



Potential Error Messages:

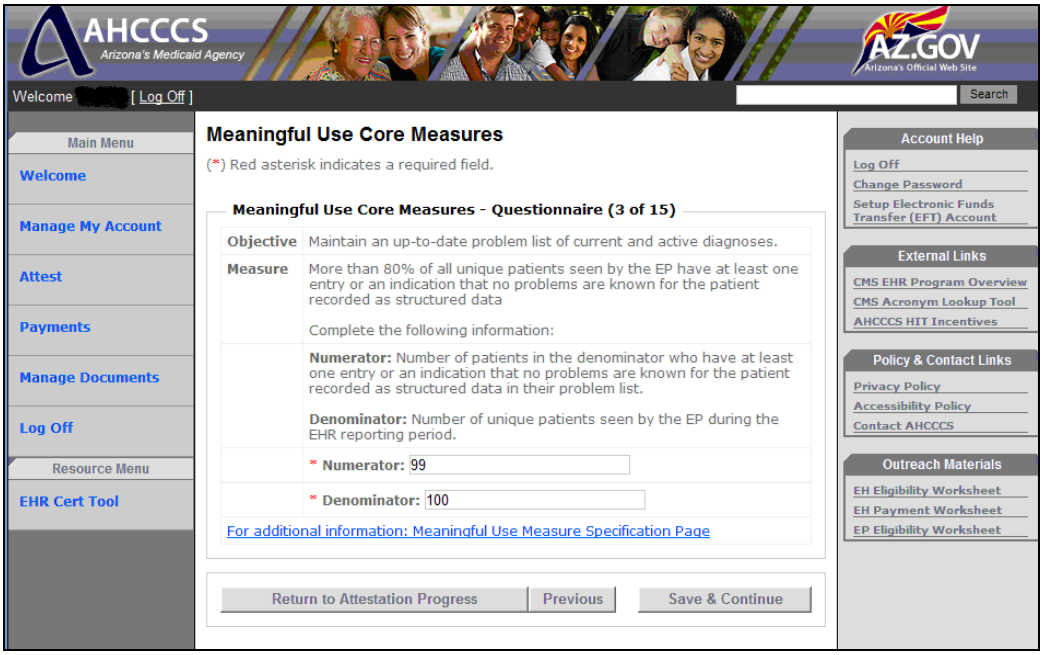
- Please select Yes or No for EXCLUSION.
- Please make a selection for Patient Records.
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator

Core Measure 2 of 15: Drug Interaction Checks

Potential Error Messages:

- Please select Yes or No

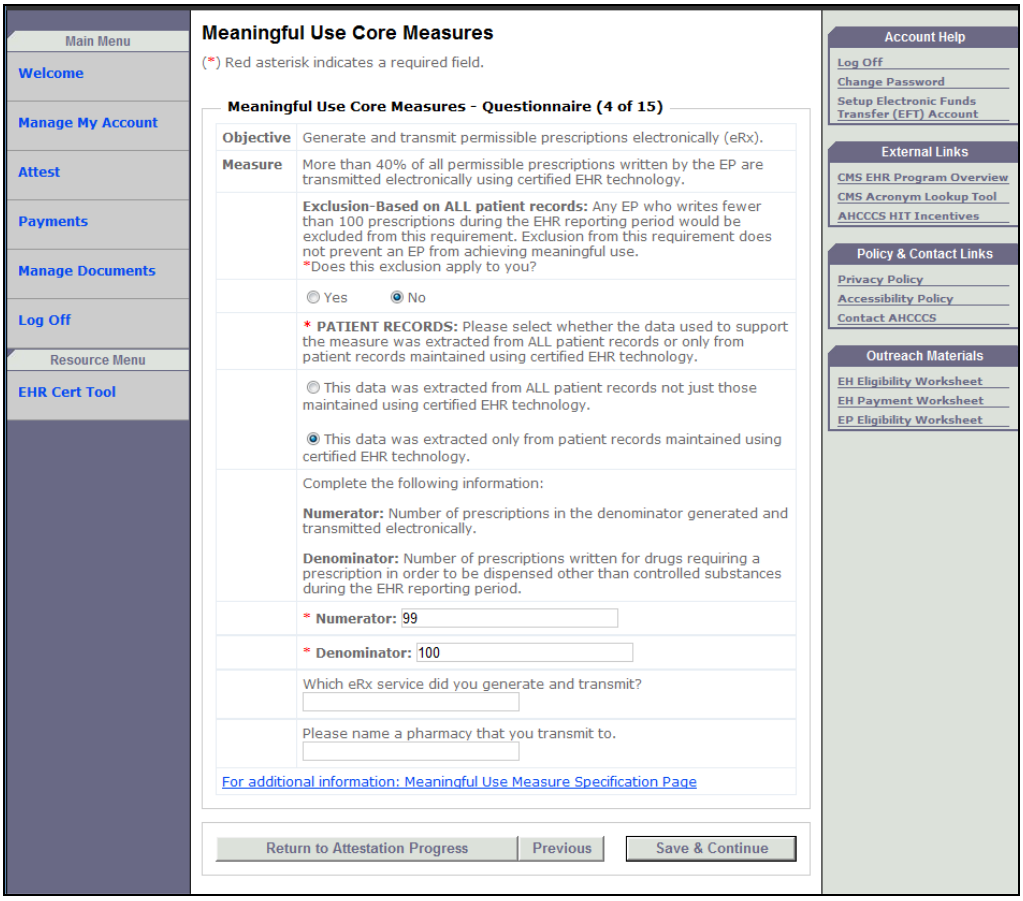
Core Measure 3 of 15: Maintain Problem List



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator

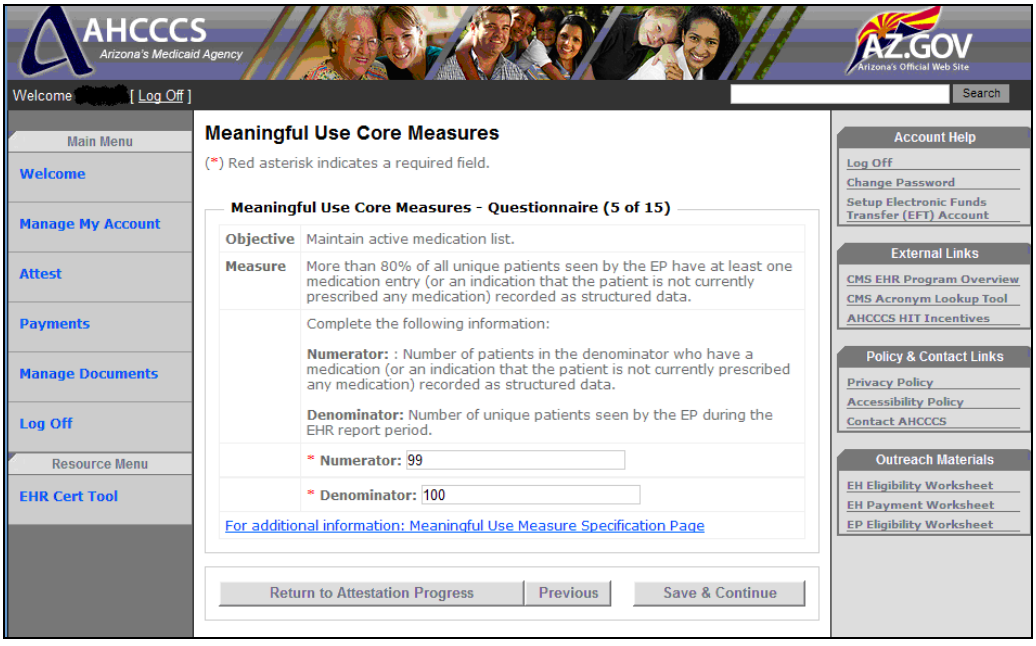
Core Measure 4 of 15: e-Prescribing (eRX)



Potential Error Messages:

- Please select Yes or No for EXCLUSION.
- Please make a selection for Patient Records.
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that equal to or less than the denominator

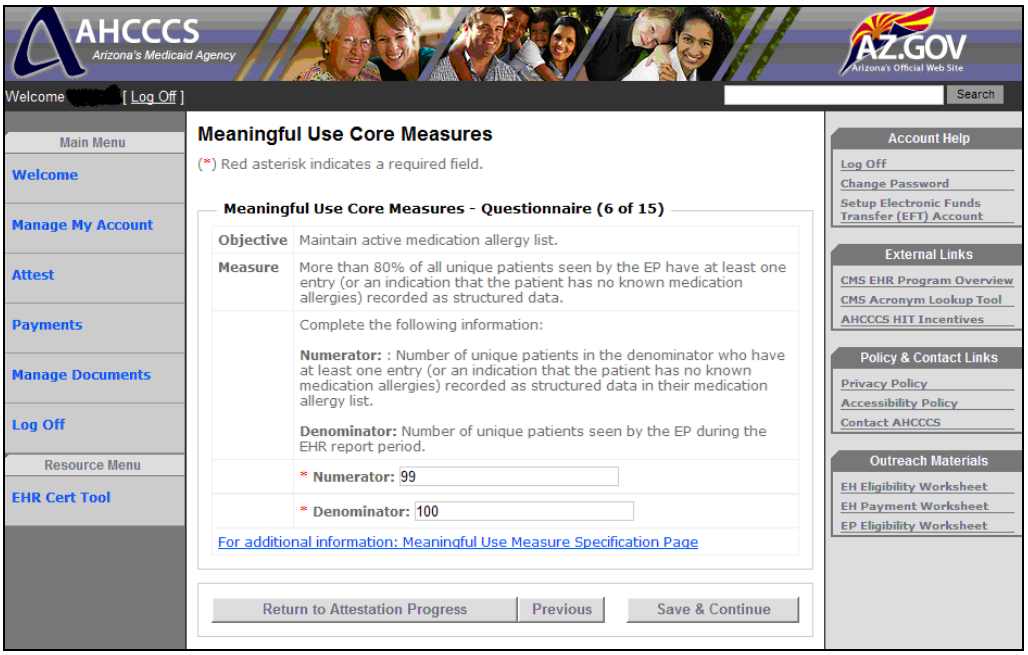
Core Measure 5 of 15: Active Medication List



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator

Core Measure 6 of 15: Medication Allergy List



Potential Error Messages:

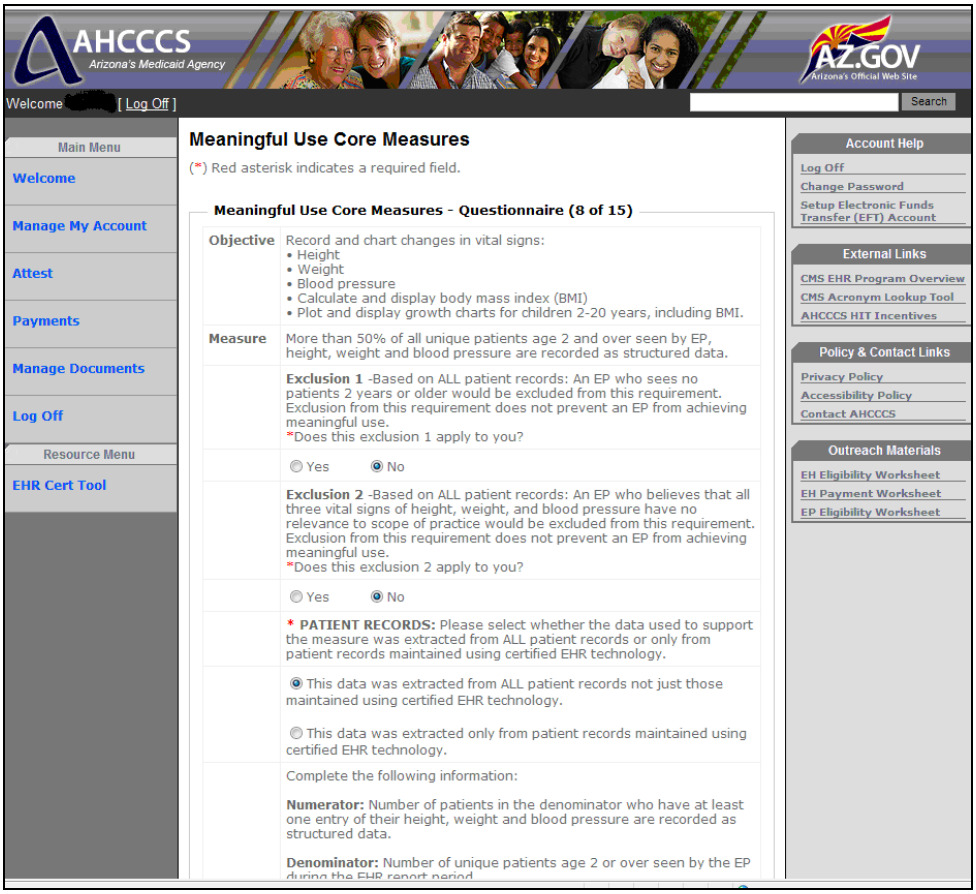
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator

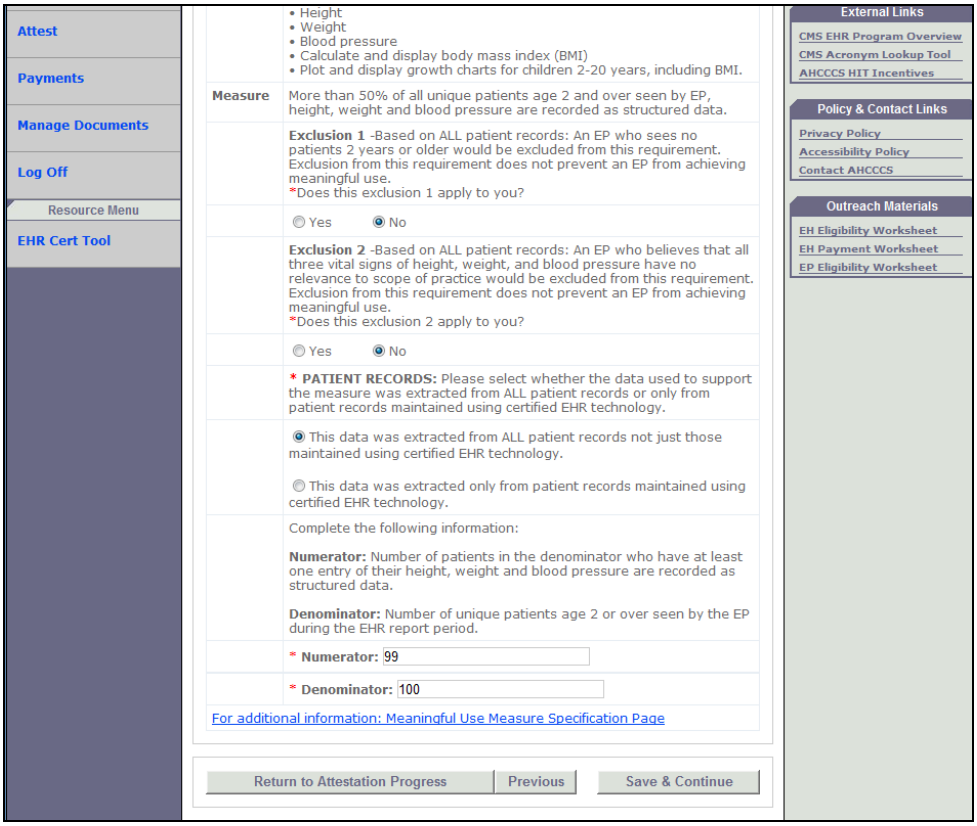
Core Measure 7 of 15: Record Demographics

Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator

Core Measure 8 of 15: Record Vital Signs

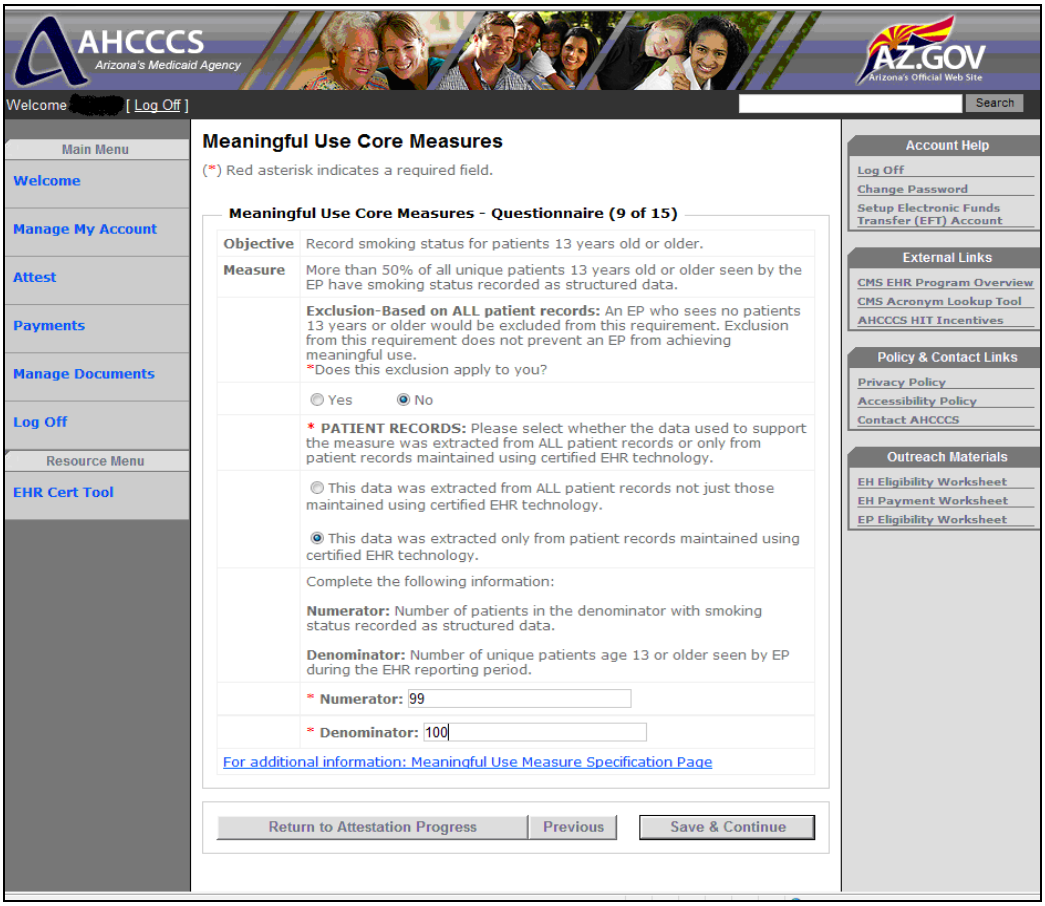




Potential Error Messages:

- Please select Yes or No for EXCLUSION.
- Please make a selection for Patient Records.
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator

Core Measure 9 of 15: Record Smoking Status



Potential Error Messages:

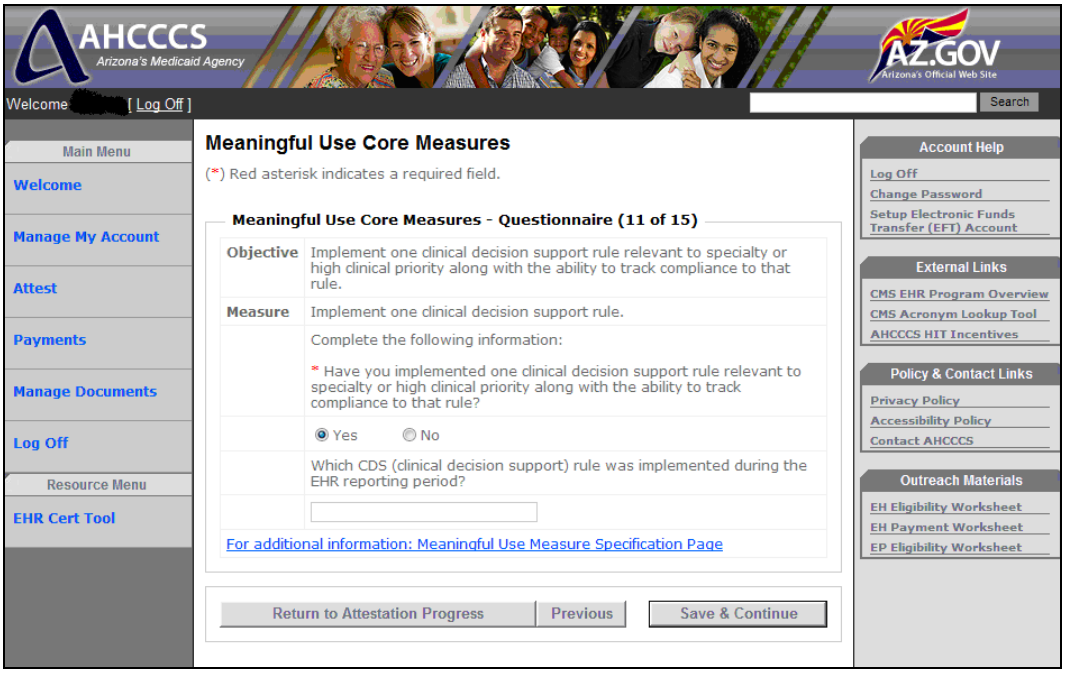
- Please select Yes or No for EXCLUSION.
- Please make a selection for Patient Records.
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator

Core Measure 10 of 15: Clinical Quality Measures (CQMs)

Potential Error Messages:

- Please select Yes or No

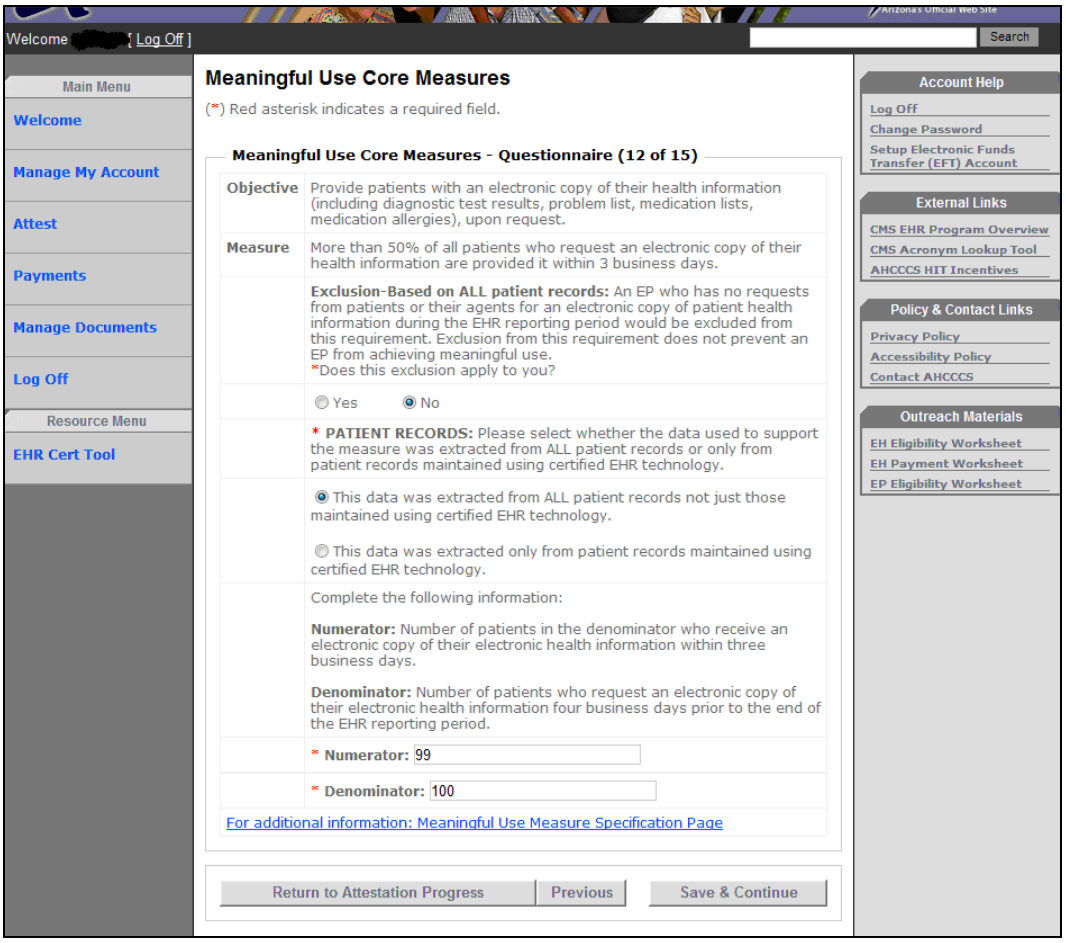
Core Measure 11 of 15: Clinical Decision Support Rule



Potential Error Messages:

- Please select Yes or No

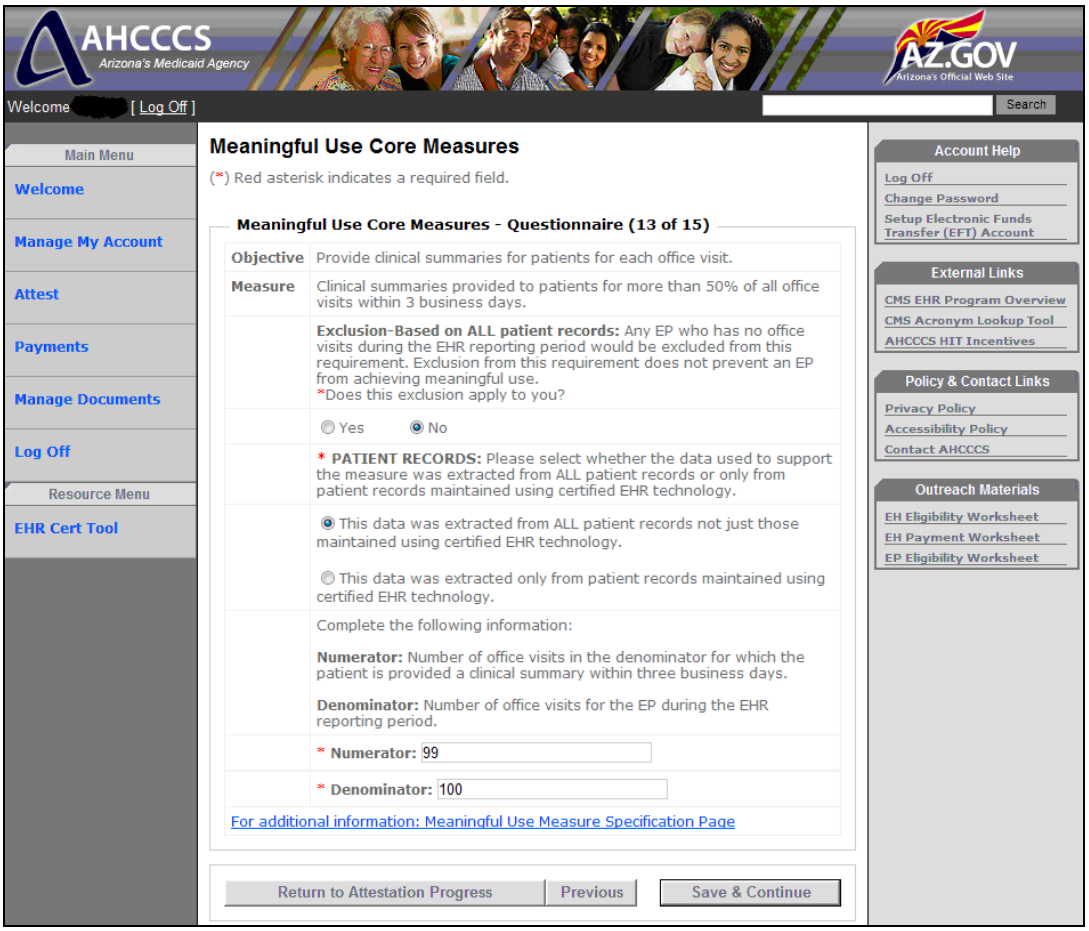
Core Measure 12 of 15: Electronic Copy of Health Information



Potential Error Messages:

- Please select Yes or No for EXCLUSION.
- Please make a selection for Patient Records.
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator

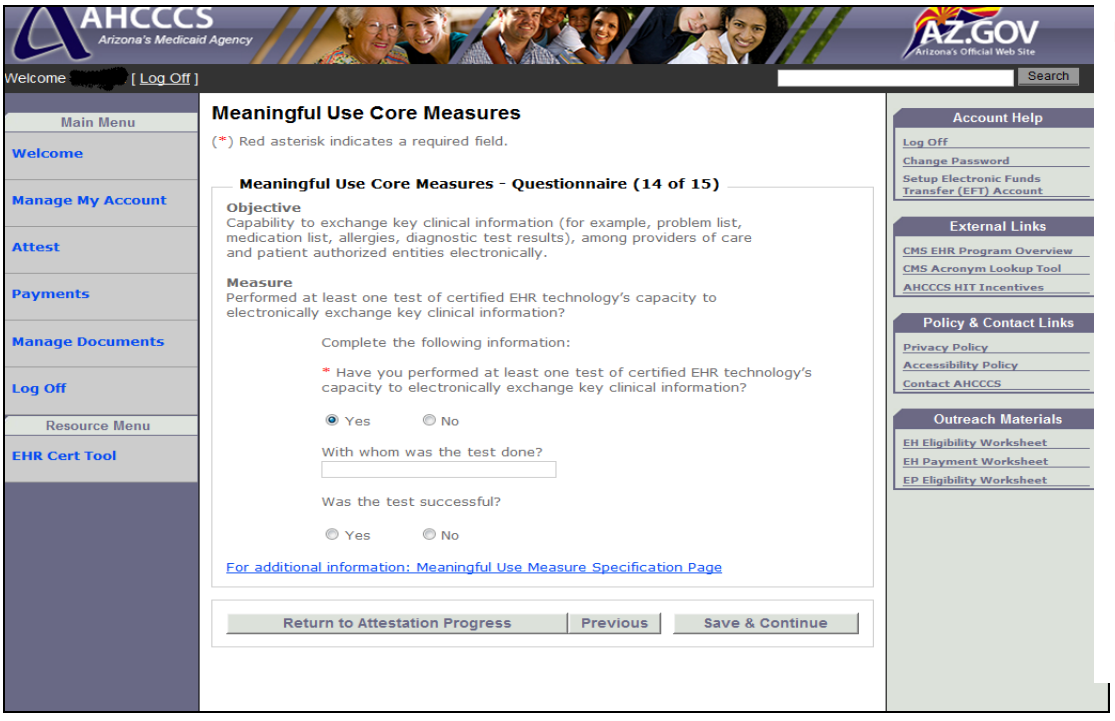
Core Measure 13 of 15: Clinical Summaries



Potential Error Messages:

- Please select Yes or No for EXCLUSION.
- Please make a selection for Patient Records.
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator

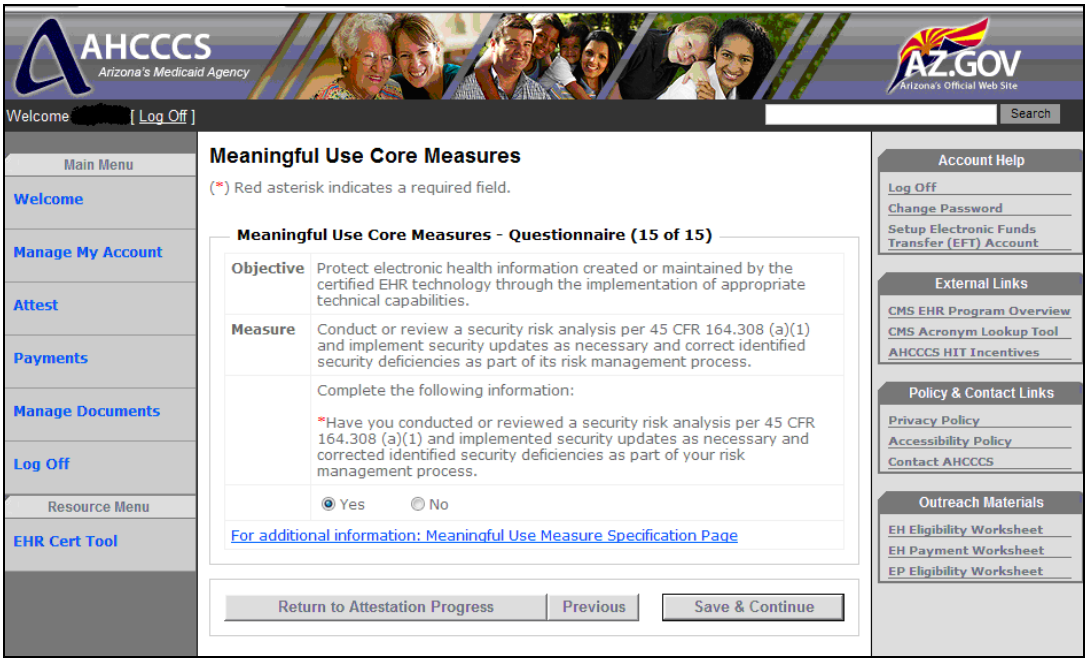
Core Measure 14 of 15: Electronic Exchange of Clinical Information



Potential Error Messages:

- Please select Yes or No

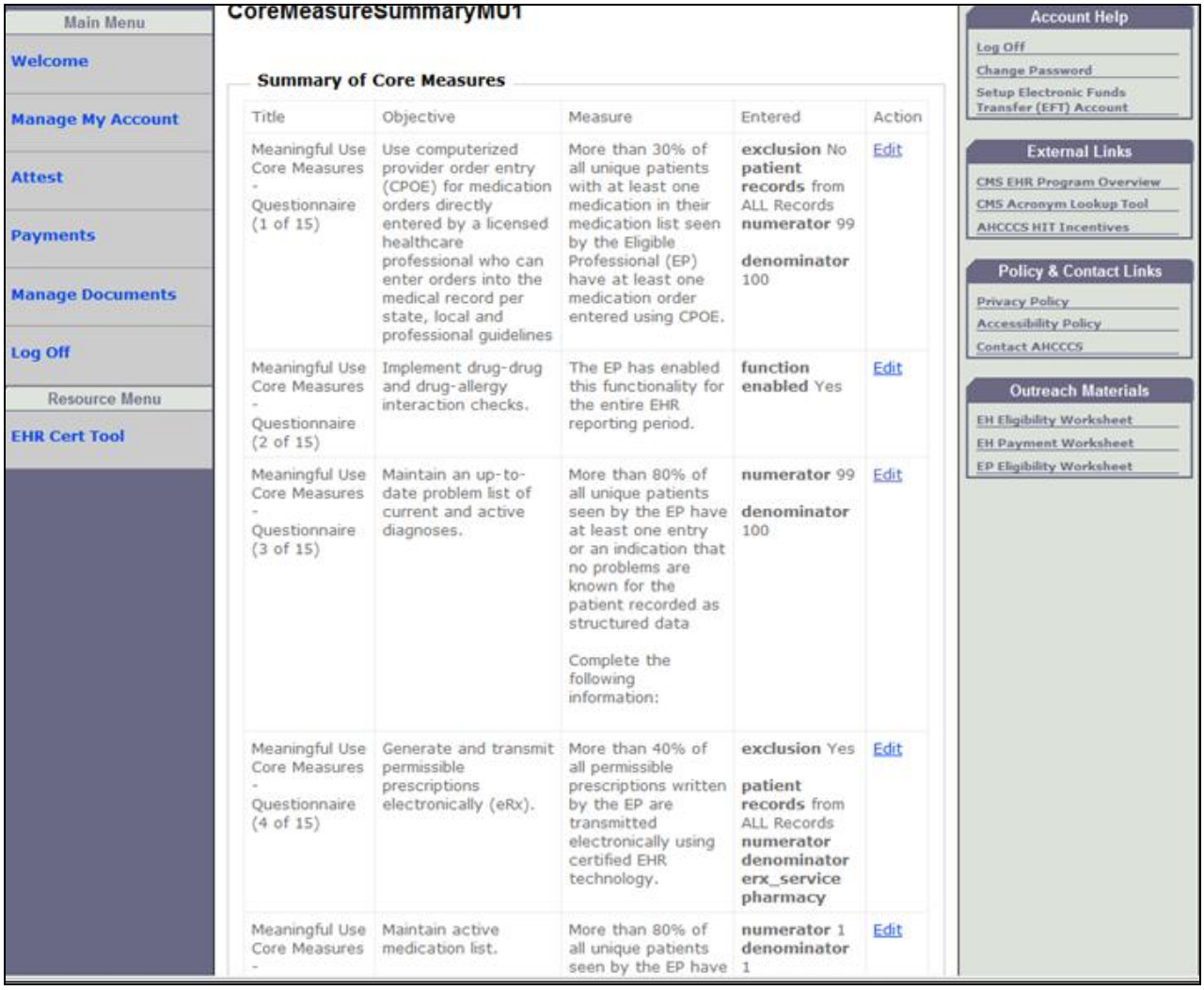
Core Measure 15 of 15: Protect Electronic Health Information



Potential Error Messages:

- Please select Yes or No

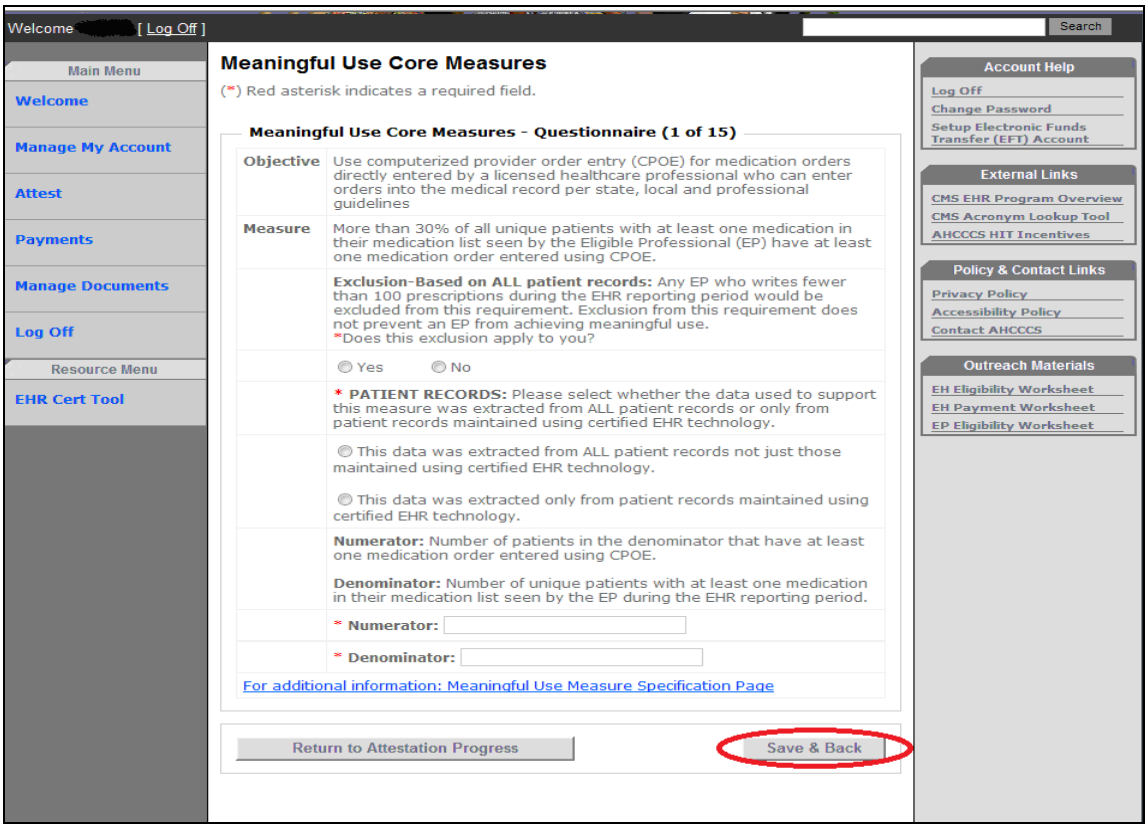
MU Core Measure Summary



NOTE: This screen lists the Title, Objective, Measure, and Data entered by the EP for all the Core Measures.

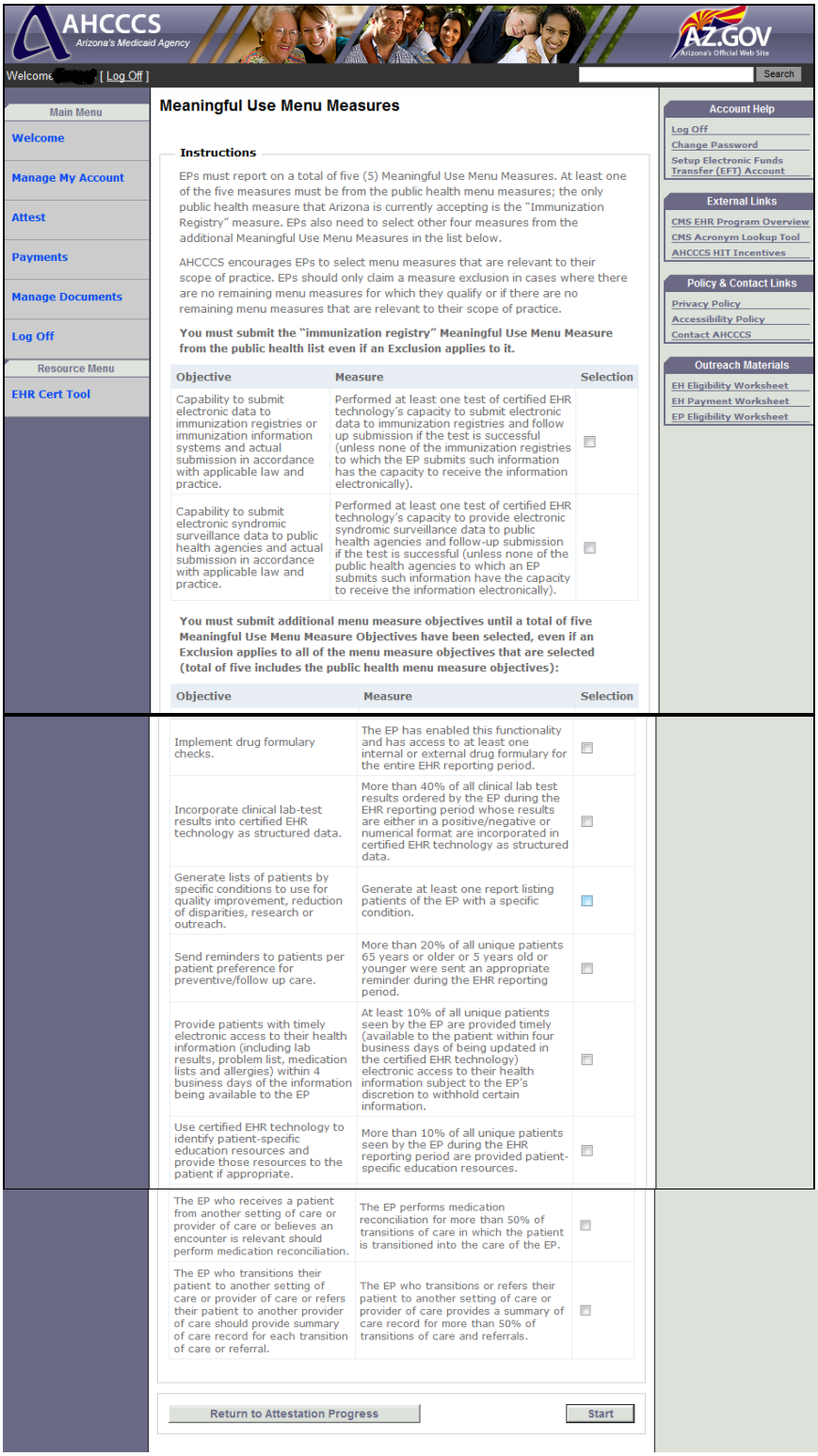
Click "**Return to Attestation Progress"** to return to the Attestation Progress page, Click "**Continue"** to go to Menu Measure home page.

Clicking "**Edit**" navigates the EP to the corresponding measure, as shown in the sample on the next page.



Click "**Save & Back"** to return to the MU Core Measure Summary page.

MEANINGFUL USE MENU MEASURES



NOTE: The user is required to select one Public Health Menu Measure (**currently the only one can be selected in Arizona is Immunization Registry**) and four additional Menu Measures.

Clicking the "**Start"** button will validate the user selection and present any errors. If no errors are indicated, the data is saved and the user is navigated to the Menu Measure questionnaire.

Click "**Return to Attestation Progress"** to return to the Attestation Progress page.

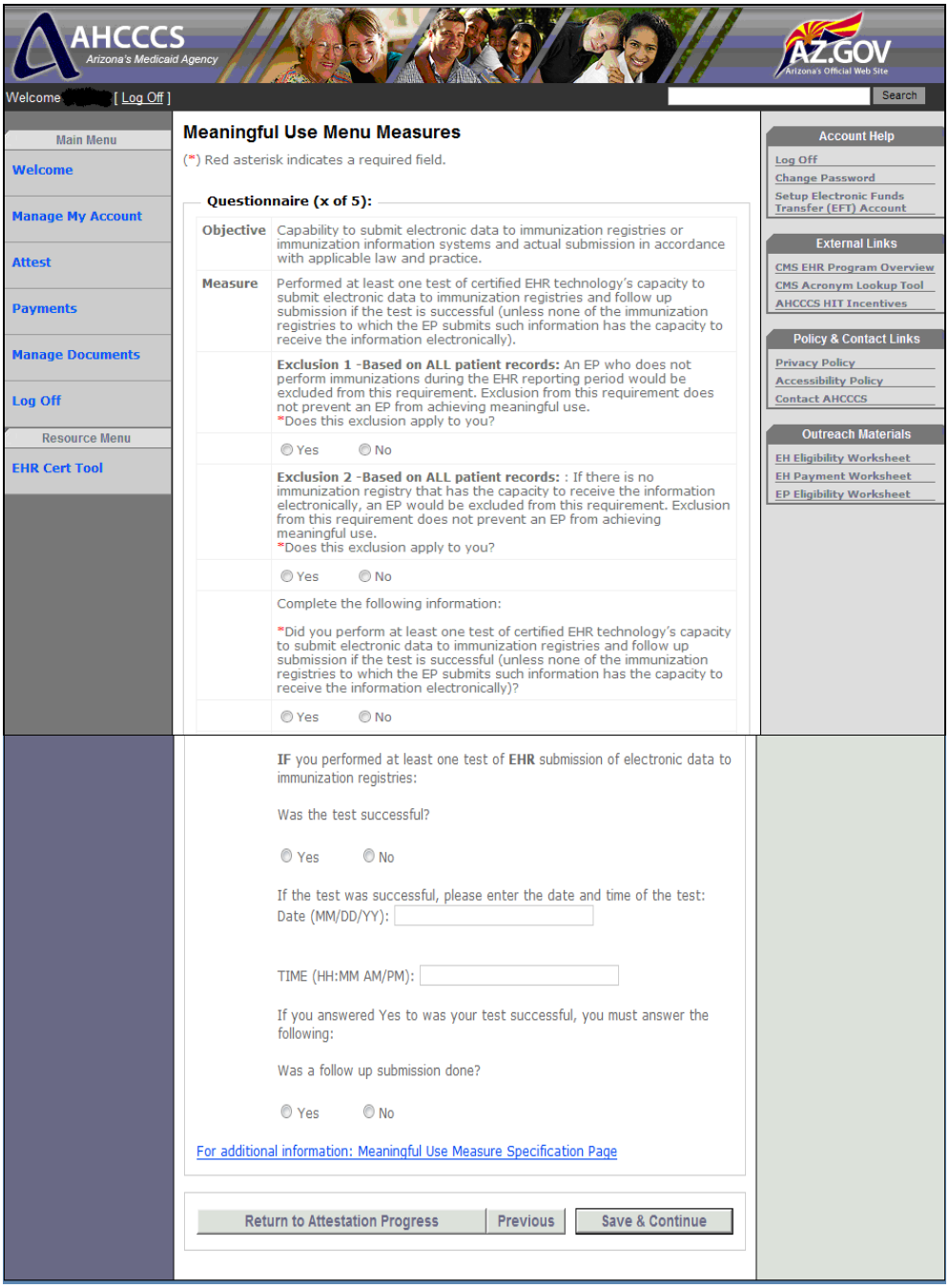
General Information for Menu Measures:

- The user is required to enter a numerator and denominator or answer Yes/No for each measure unless the user can claim an exclusion.
  - If the user selects "Yes" for an Exclusion, all other fields will be hidden.
- The user must enter all required fields as indicated by the red asterisks.
- The denominator must be >= numerator and exclusions; all data must be non-negative whole numbers.
- Clicking the "**Save & Continue**" button on each screen will validate the data and present any errors.
  - Potential error messages for each screen are described for reference.
- If the system does not determine any errors, the data is saved and the user is navigated to the next Menu Measure page.
- Clicking the "**Previous Page"** button will navigate the user to the previous Menu Measure Page.
- Clicking the "**Return to Attestation Progress"** button will navigate the user to the Attestation Progress Page.
- Click **"For detailed information about this measure, please click here"** link for the specific requirements and related definitions for each measure.

Potential Error Messages:

- Please select at least one public health menu measure objective.
- Please select a total of five (5) Meaningful Use Menu Measure Objectives (includes Meaningful Use Menu Measure from the public health list).

Menu Measure 1 of 10: Immunization Registry



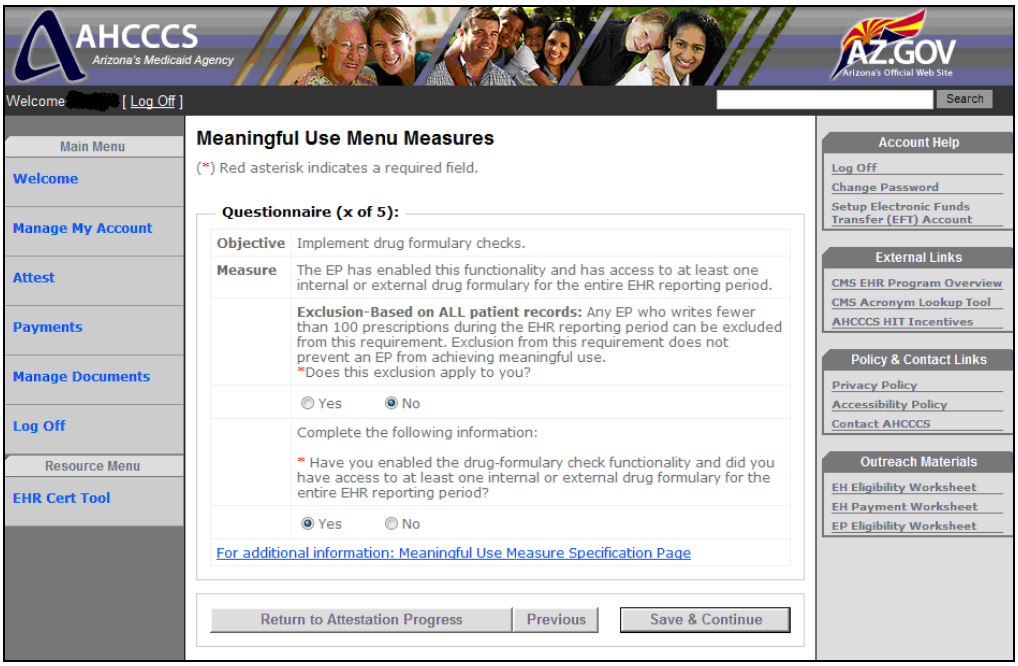
Potential Error Messages:

- Please select Yes or No for the Exclusion
- Please select Yes or No

Meaningful Use Menu Measure 2 of 10: Syndromic Surveillance

NOTE: This measure is not selectable as Arizona is not currently accepting this measure.

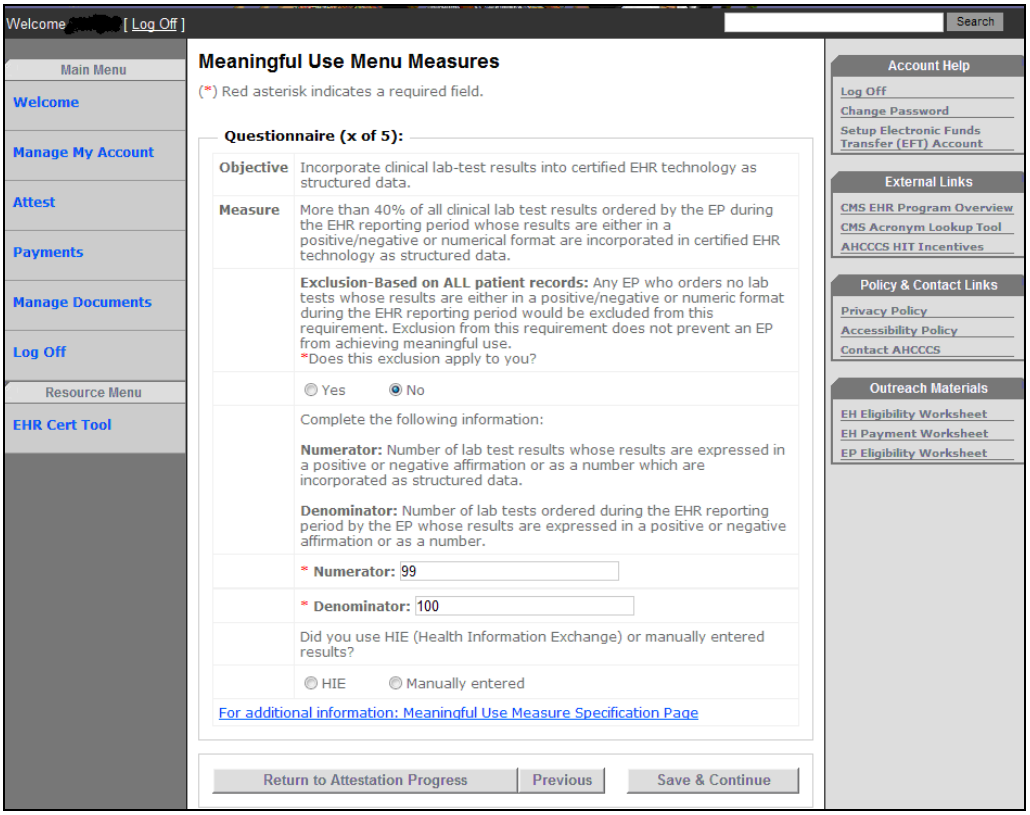
Menu Measure 3 of 10: Drug Formulary Checks



Potential Error Messages:

- Please select Yes or No for the Exclusion
- Please select Yes or No

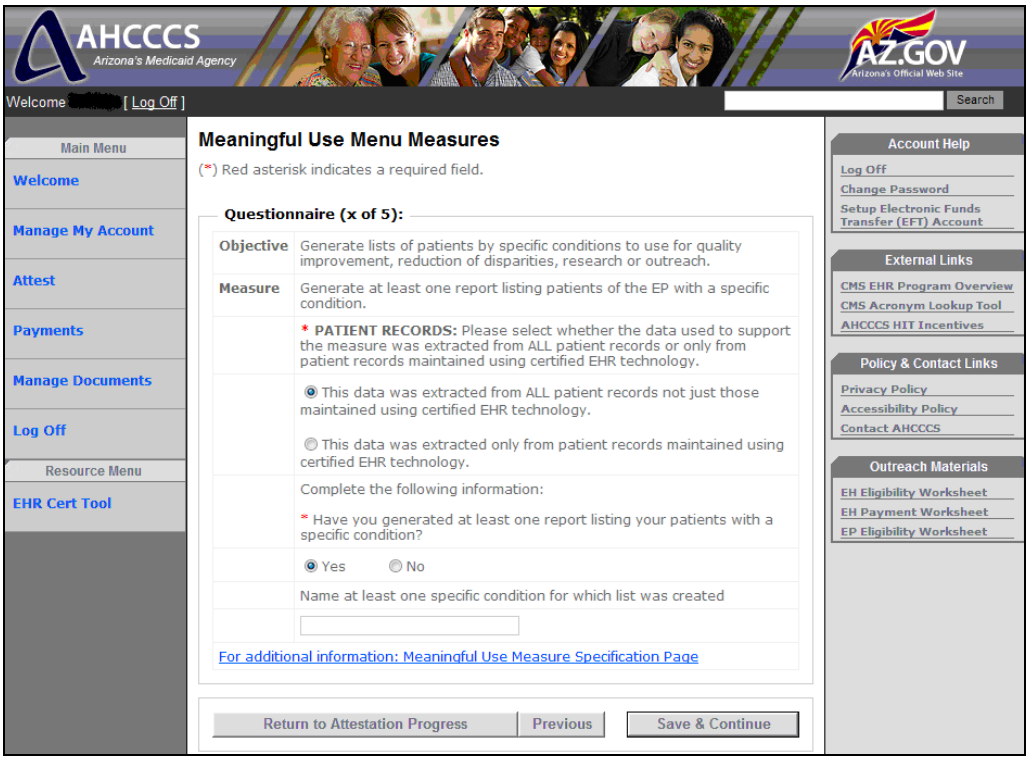
Menu Measure 4 of 10: Clinical Lab Test Results



Potential Error Messages:

- Please select Yes or No for the Exclusion.
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator

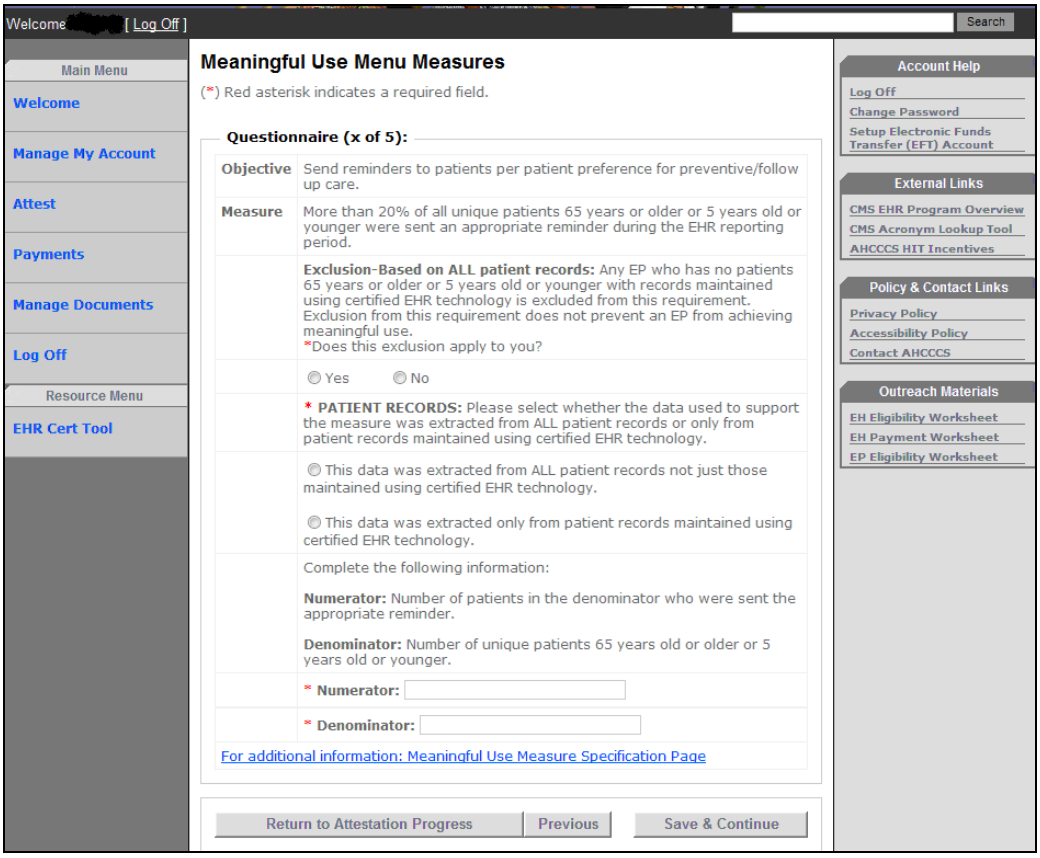
Menu Measure 5 of 10: Patient Lists



Potential Error Messages:

- Please make a selection for Patient Records.
- Please select Yes or No.

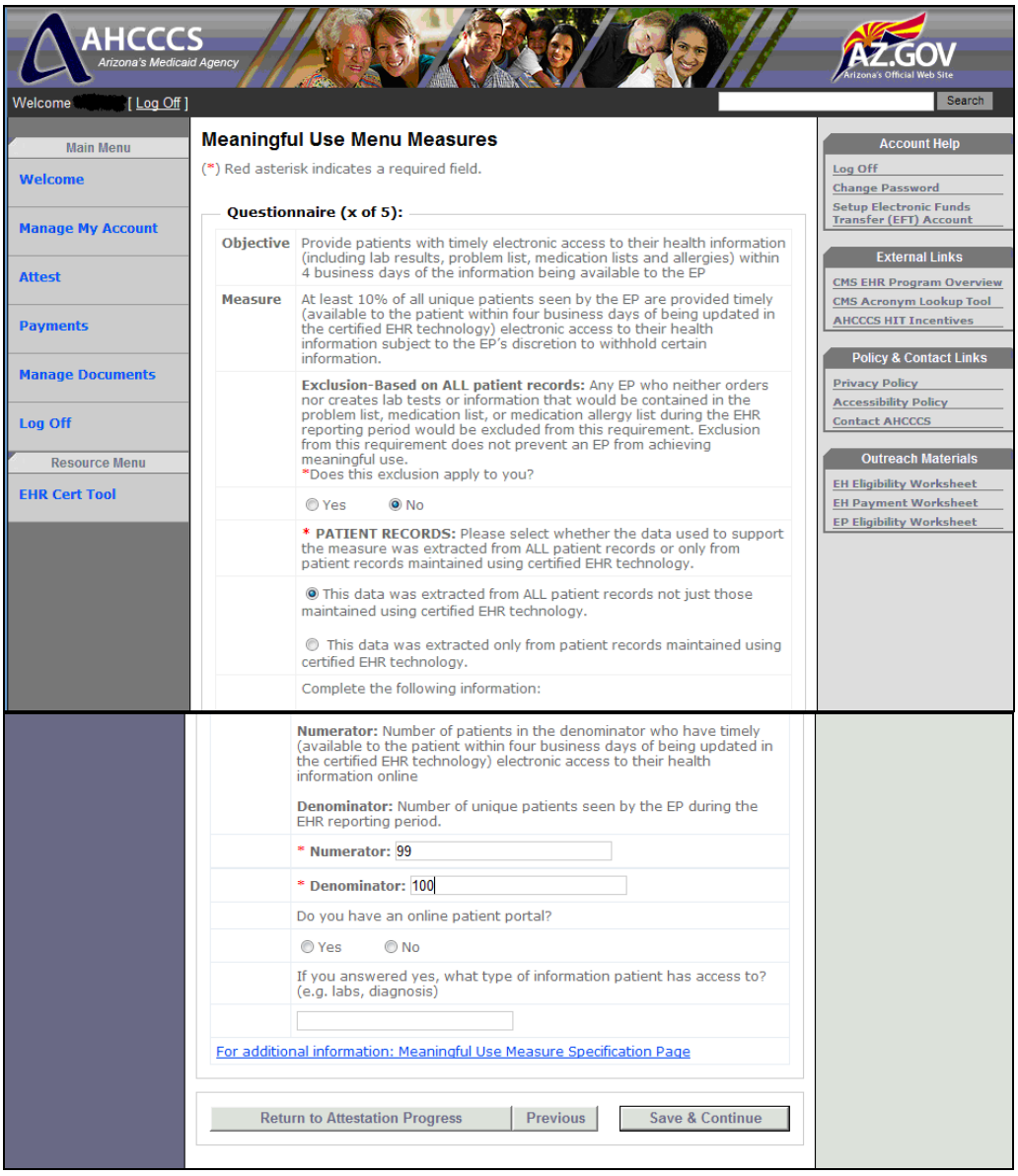
Menu Measure 6 of 10: Patient Reminders



Potential Error Messages:

- Please select Yes or No for EXCLUSION.
- Please make a selection for Patient Records.
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

Menu Measure 7 of 10: Patient Electronic Access



Potential Error Messages:

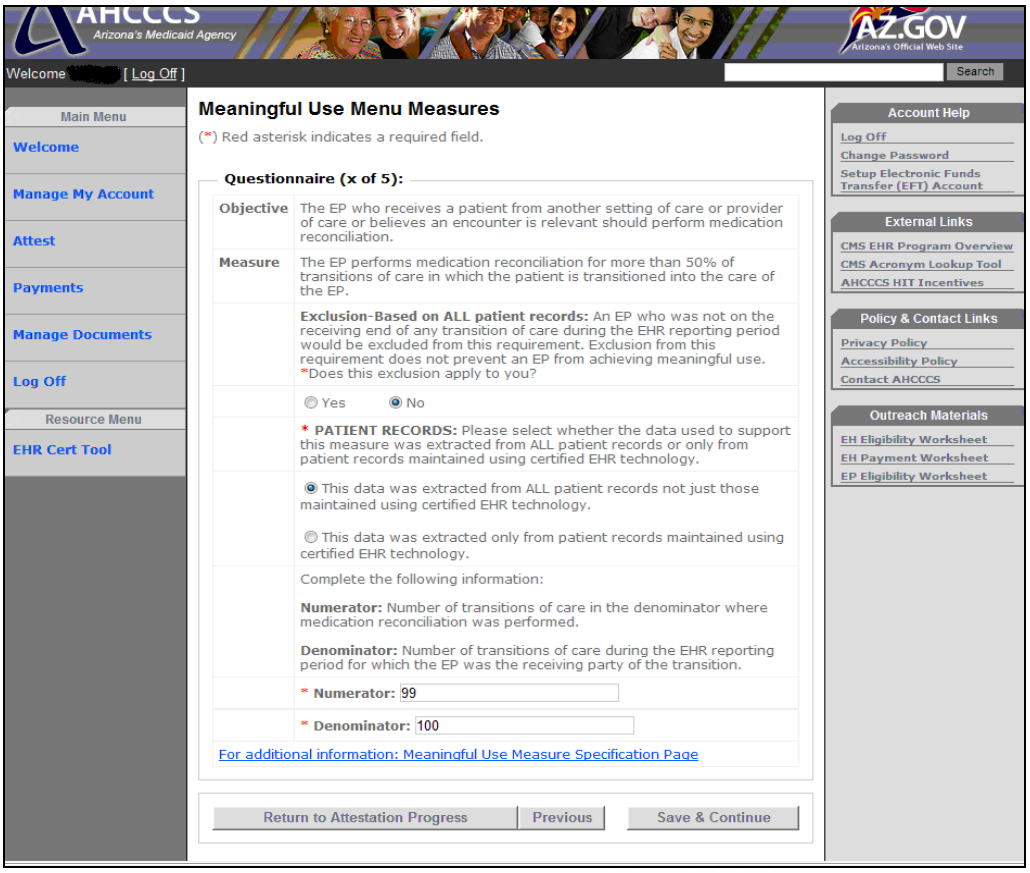
- Please select Yes or No for EXCLUSION.
- Please make a selection for Patient Records.
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

Menu Measure 8 of 10: Patient-Specific Education Resources

Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

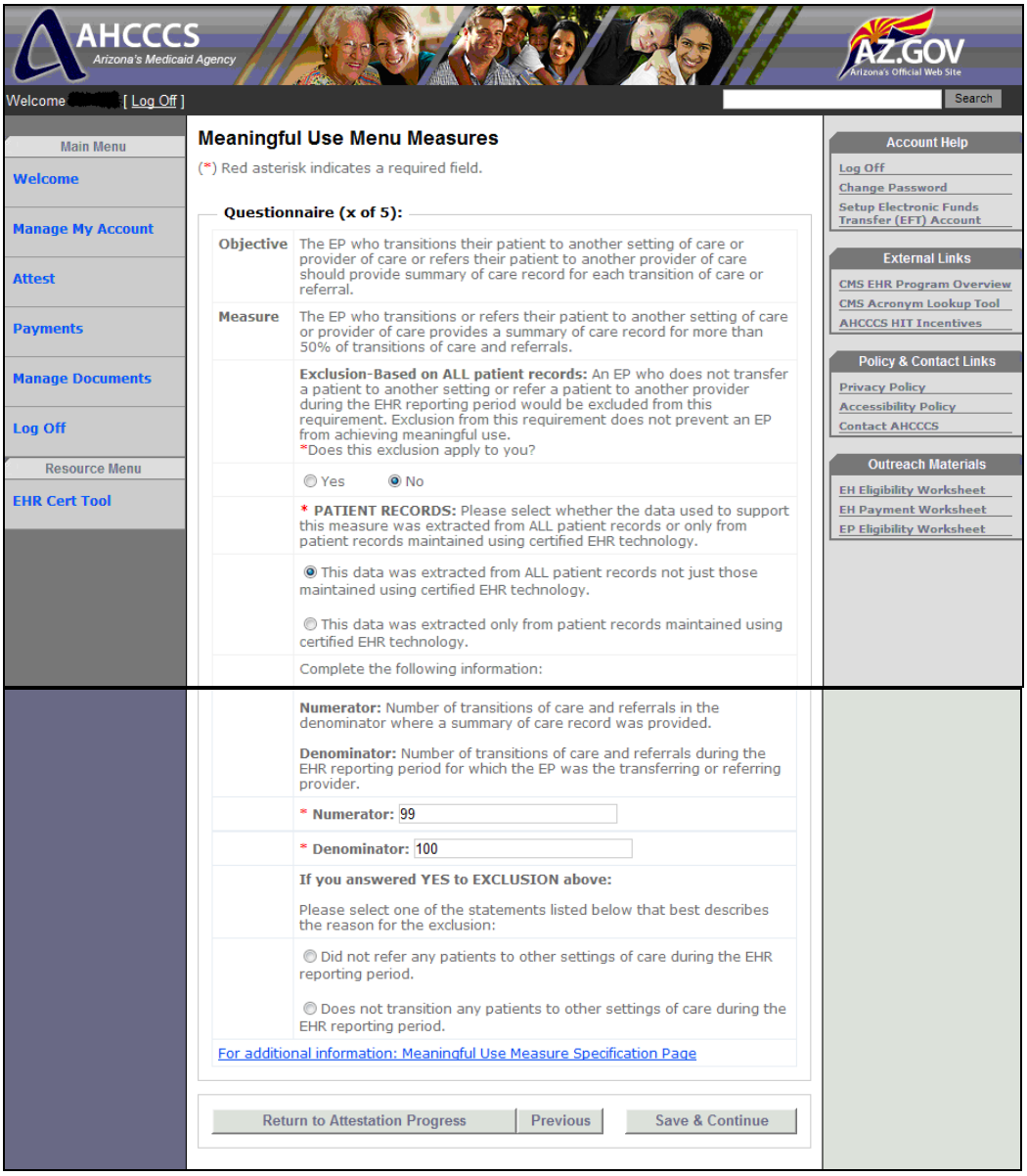
Menu Measure 9 of 10: Medication Reconciliation



Potential Error Messages:

- Please select Yes or No for EXCLUSION.
- Please make a selection for Patient Records.
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator

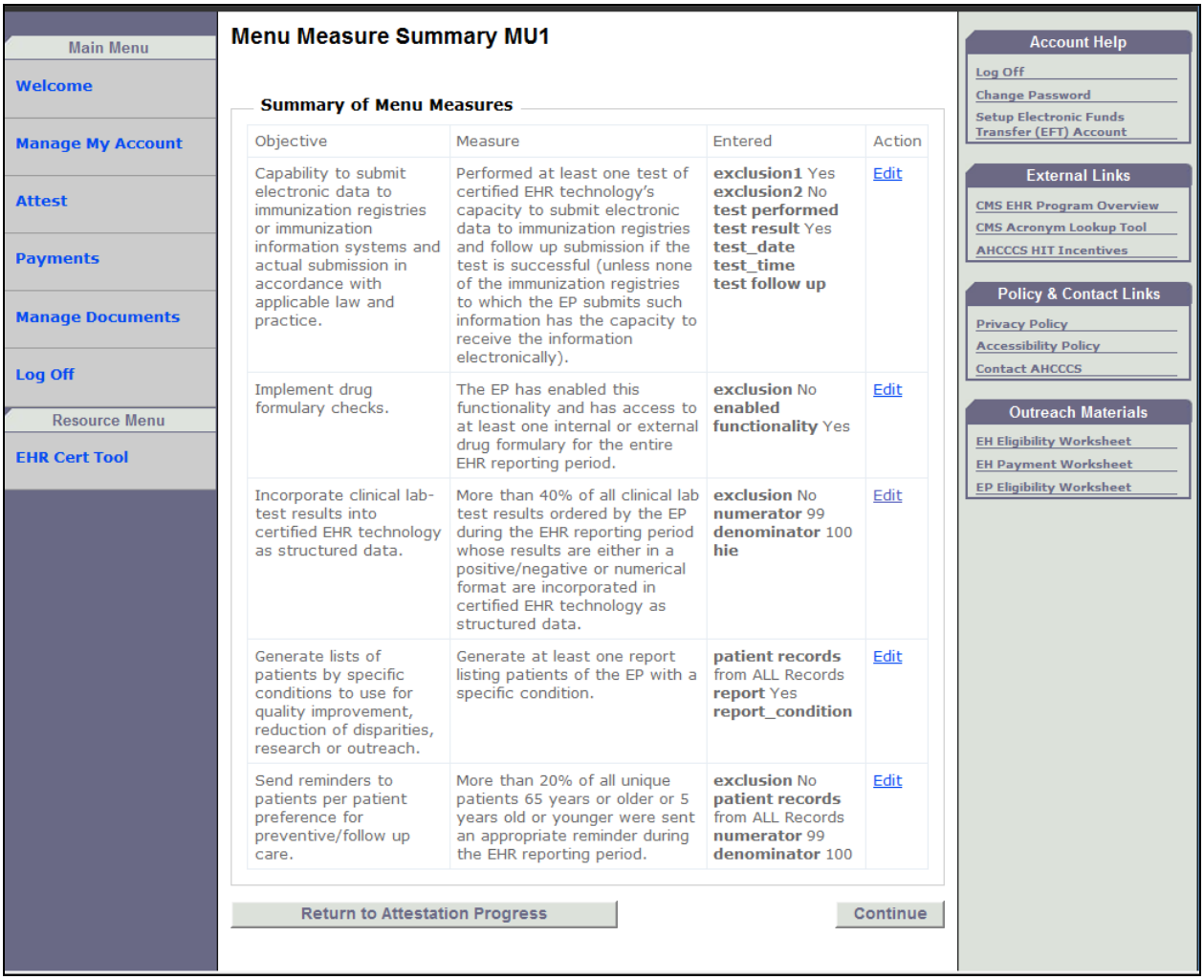
Menu Measure 10 of 10: Transition of Care Summary



Potential Error Messages:

- Please select Yes or No for EXCLUSION.
- Please make a selection for Patient Records.
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator

Menu Measure Summary Page



Note: This screen lists the Objective, Measure, and Data entered by the EP for all the Core Measures. EPs can click the "**Edit**" button on a measure row to go to that measure and update the data entry.

Click "**Return to Attestation Progress**" button will navigate the user to the Attestation Progress Page; Click "**Continue"** to go to the Clinical Quality Measure home page.

MEANINGFUL USE CLINICAL QUALITY MEASURES

Clinical Quality Measures Instructions

NOTE:
EPs must report calculated CQMs directly from their certified EHR technology as a requirement of the EHR Incentive Programs. Each EP must report on 3 Core Clinical Quality Measures (CQM) and/or up to 3 Alternate CQMs (If an EP reports a denominator of 0 for any of the 3 Core CQMs, the EP must report for an Alternate Core CQM to supplement the Core CQM) and 3 Additional CQMs that relate to their practice (the EP must select 3 out of 38 Additional CQMs provided). Zero is an acceptable CQM denominator value provided that this value was produced by certified EHR technology.

General Information for all Clinical Quality Measures:

- The user is required to enter the numerator, denominator and exclusions (if any) for each measure.
- Clicking the Save & Continue button will validate the data and present any errors.
- The user must enter all required fields.
- The denominator must be >= numerator and exclusions; all data must be non-negative whole numbers.
- If the system does not determine any errors, the data is saved and the user is navigated to the next Clinical Quality Measure page.
- Clicking the **Previous Page** button will navigate the user to the previous Clinical Quality Measure Page.
- Clicking the **Return to Attestation Progress** button will navigate the user to the Attestation Progress Page.
- Click **For detailed information about this measure, please click here** link for the specific requirements and related definitions for each measure.

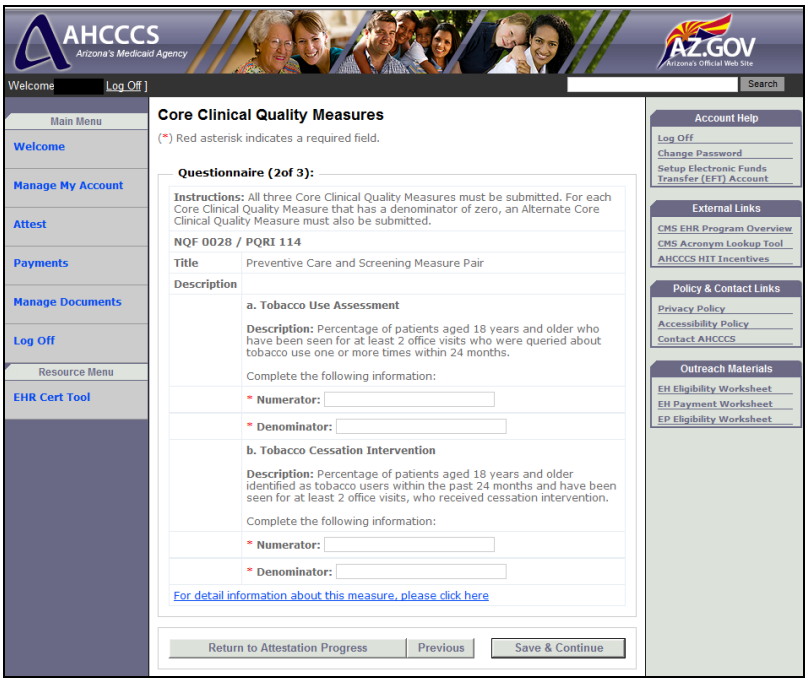
Click **Start** to begin reporting Clinical Quality Measures.

Meaningful Use Core Clinical Quality Measure 1

Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

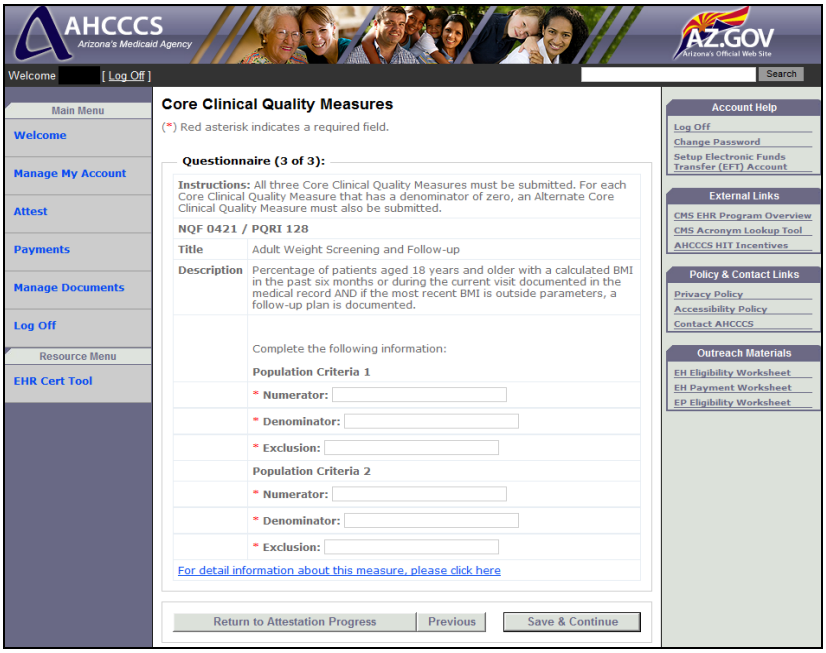
Meaningful Use Core Clinical Quality Measure 2



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

Meaningful Use Core Clinical Quality Measure 3



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

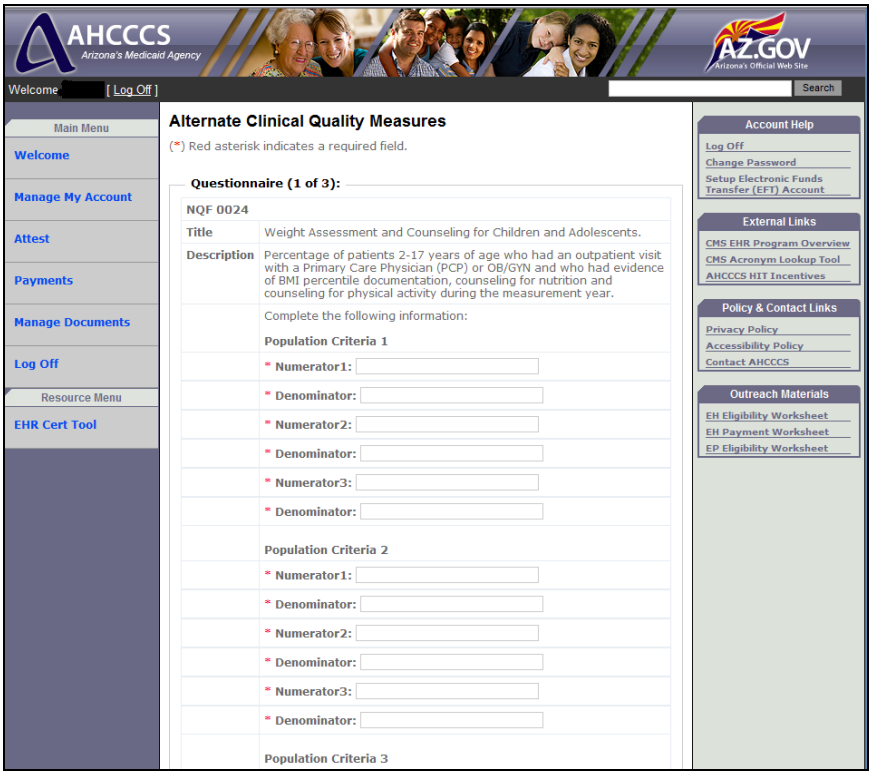
Alternative Clinical Quality Measure Instruction and Selection Page

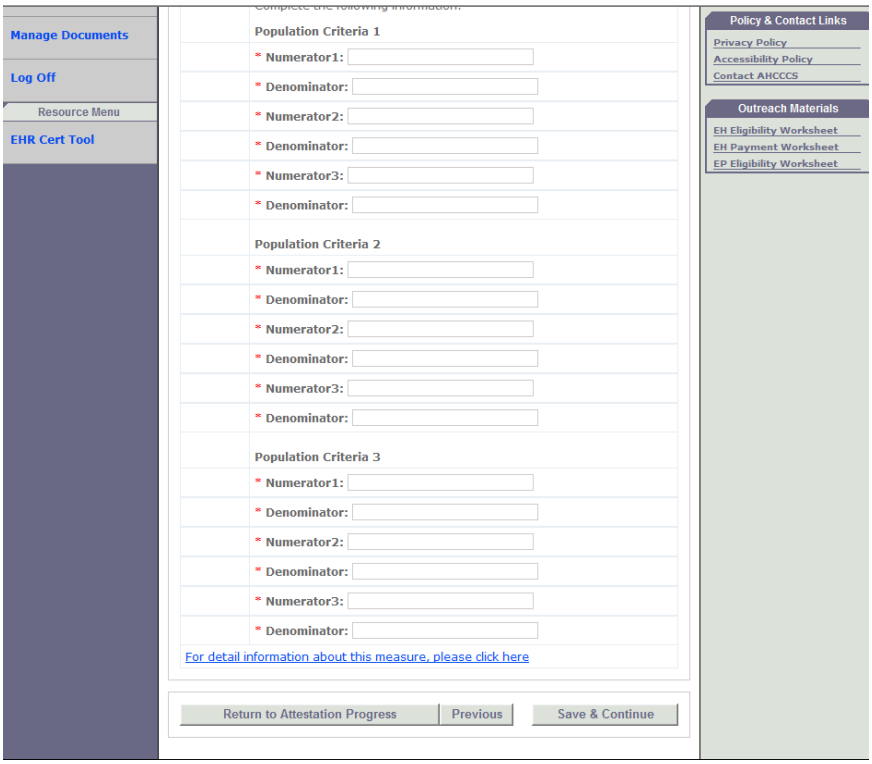
If an EP indicates a zero in the denominator of one or more Core Clinical Quality Measures, then they must choose an Alternate Clinical Quality Measure to equal the amount of Core Clinical Quality Measures that had a zero in the denominator.

This menu only appears after the Core Clinical Quality Measures if zero is reported in the denominator of one or more Core Clinical Quality Measures. If none of the denominators are zero for the Core Clinical Quality Measures, an EP will be navigated to Additional Clinical Quality Measures page.

Clicking the **Return to Attestation Progress** button will navigate the user to the Attestation Progress Page. Click **Start** to continue.

Alternative Clinical Quality Measure 1

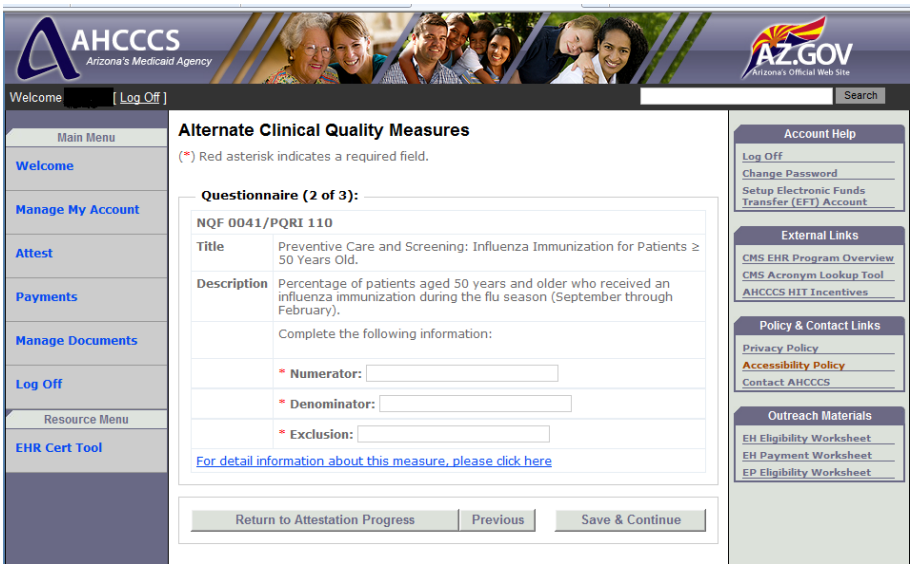




Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

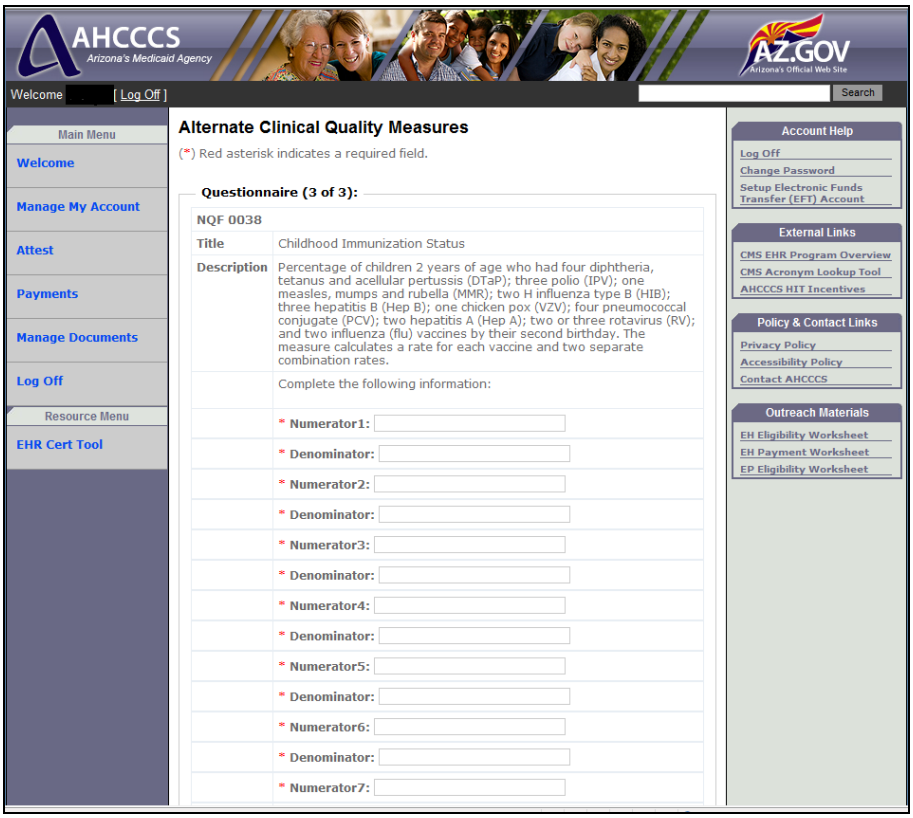
Alternative Clinical Quality Measure 2



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

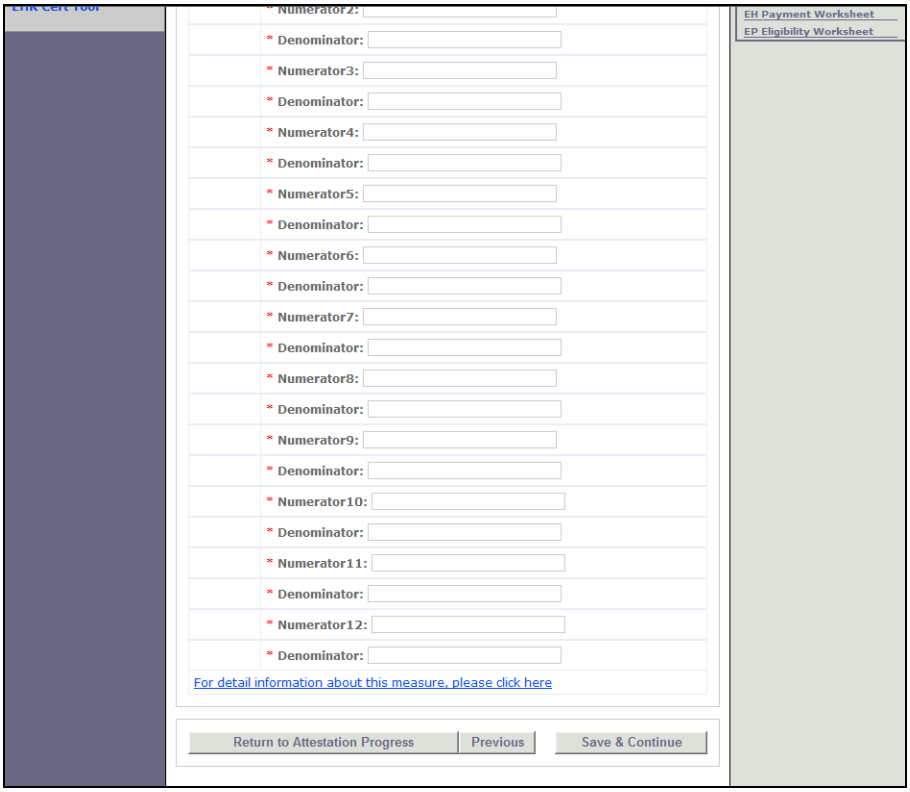
Alternative Clinical Quality Measure 3



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

Alternative Clinical Quality Measure 3, con't…



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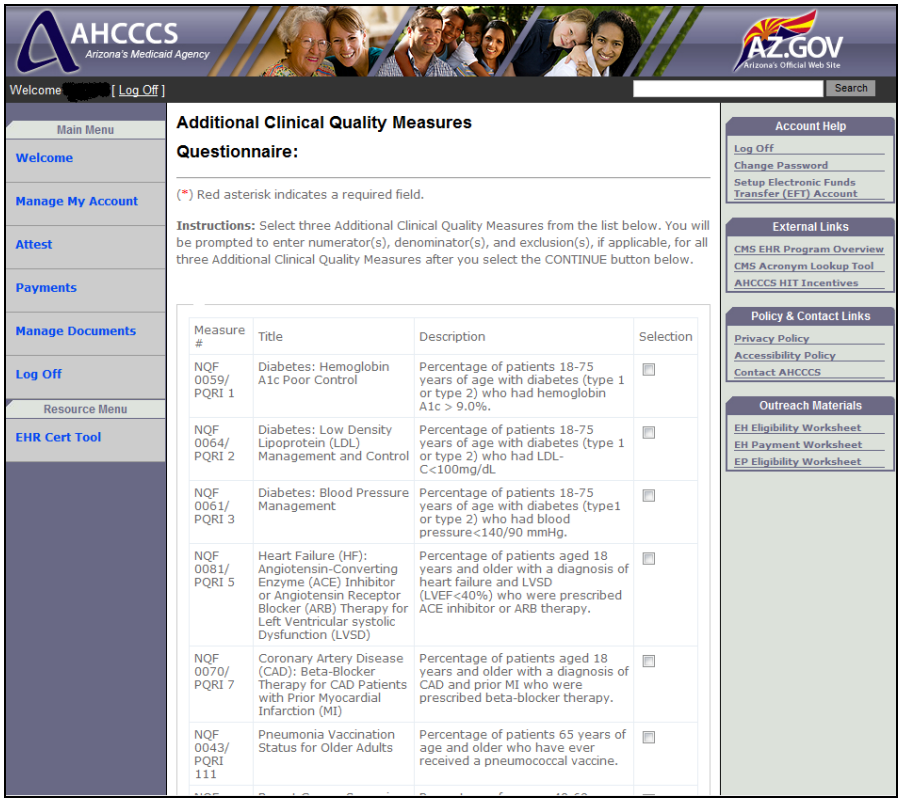
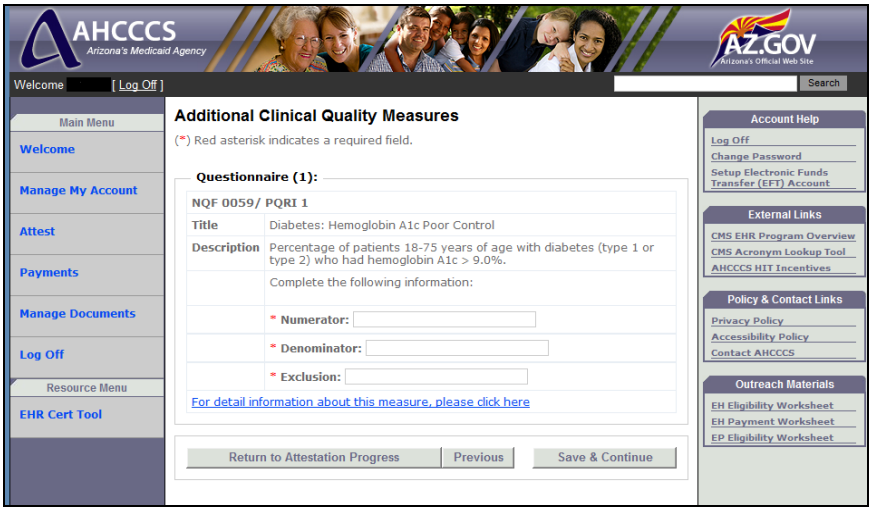
Additional Clinical Quality Measures Instruction and Selection Page



NOTE: A total of 3 Additional Clinical Quality Measures must be selected by the EP. If the EP sees no patients in the measure population, it is acceptable to report zero in the denominator as long as the data is calculated by the certified EHR technology.

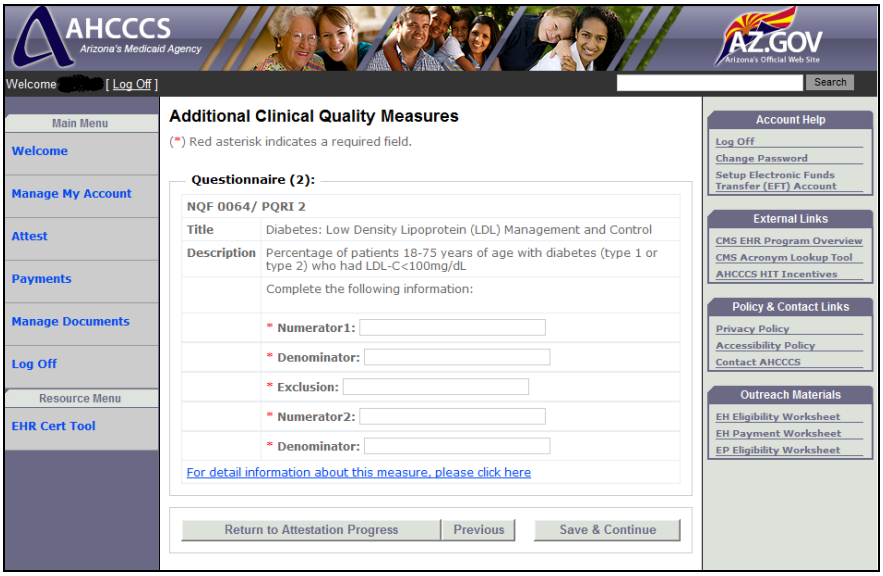
Additional Clinical Quality Measure 1



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

Additional Clinical Quality Measure 2



Potential Error Messages:

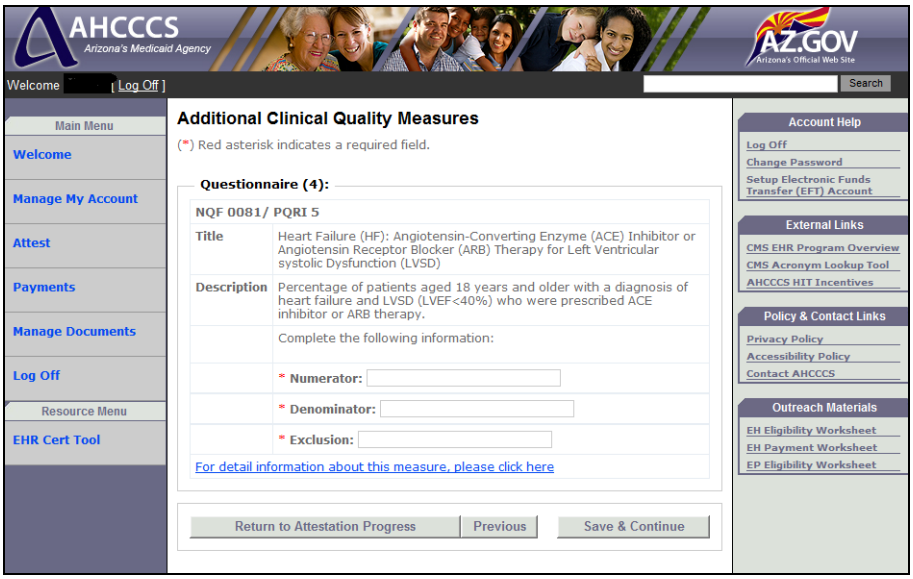
- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

Additional Clinical Quality Measure 3

Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

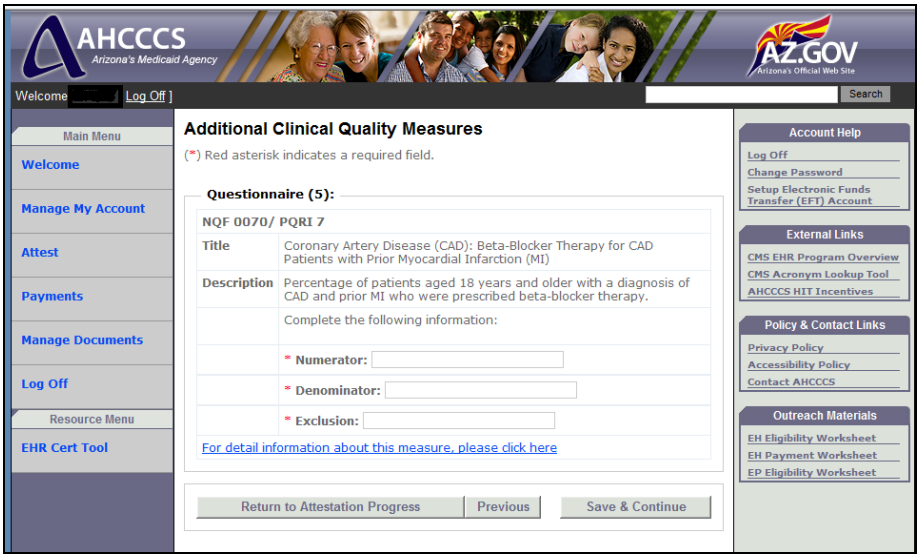
Additional Clinical Quality Measure 4



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

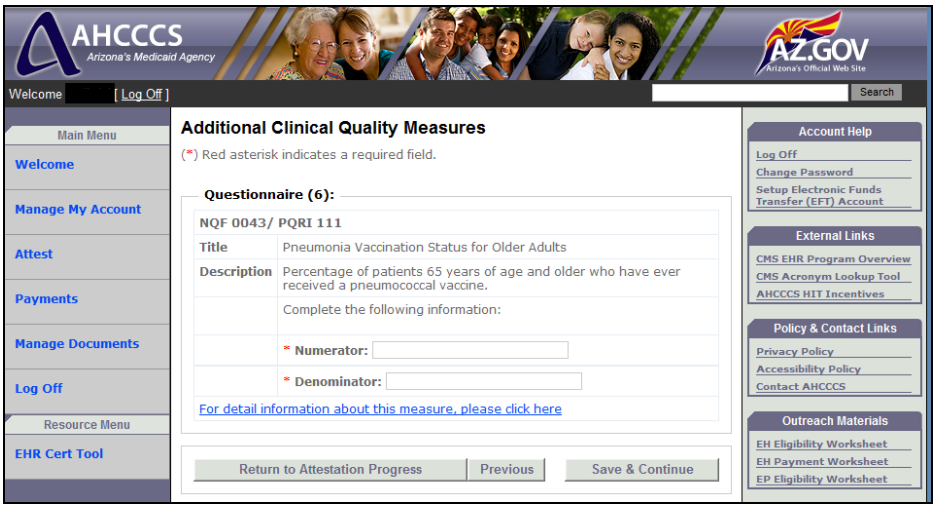
Additional Clinical Quality Measure 5



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

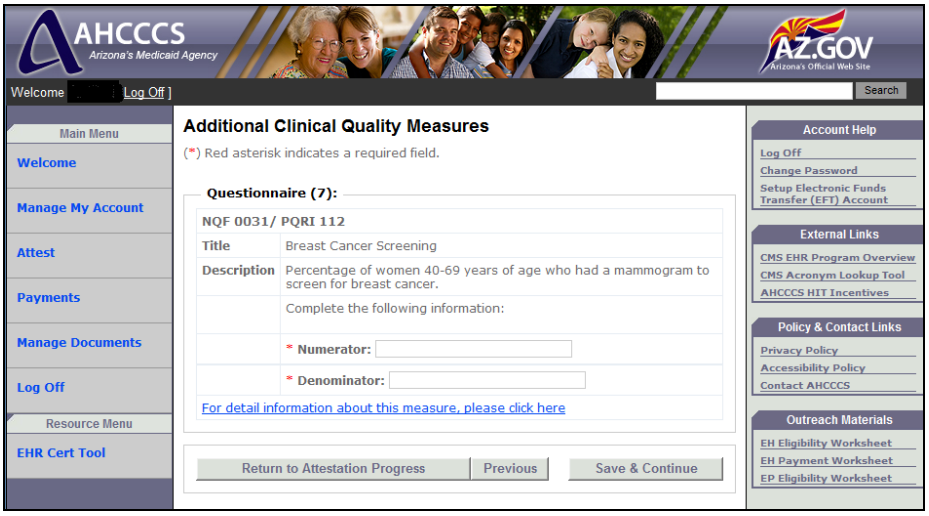
Additional Clinical Quality Measure 6



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

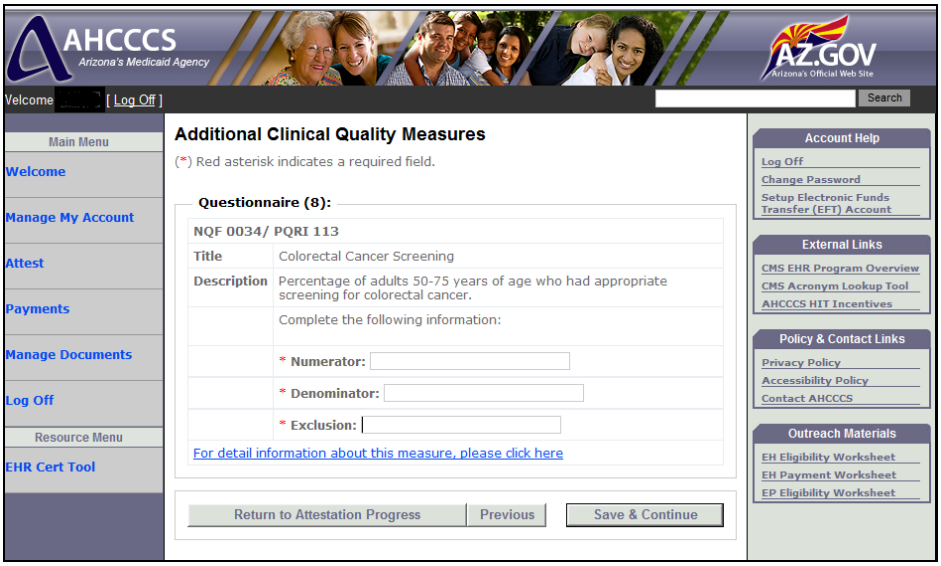
Additional Clinical Quality Measure 7



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

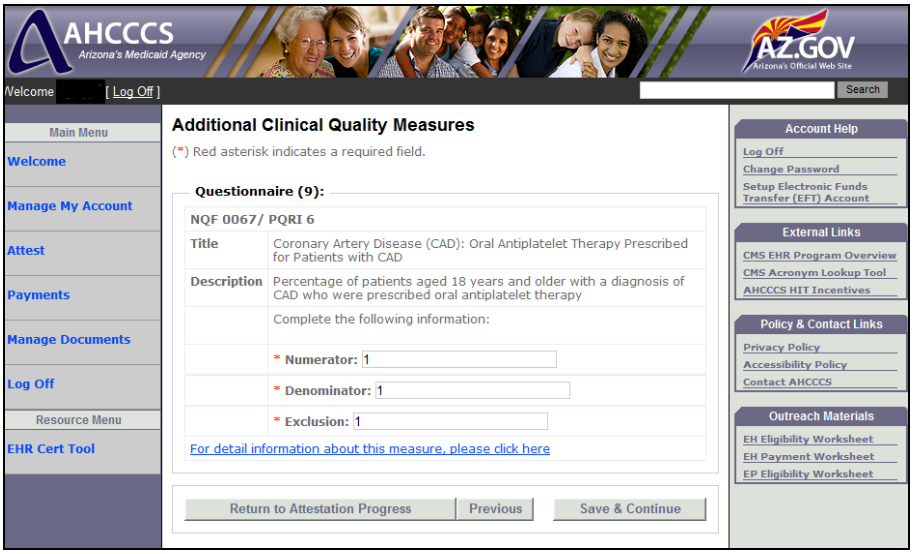
Additional Clinical Quality Measure 8



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

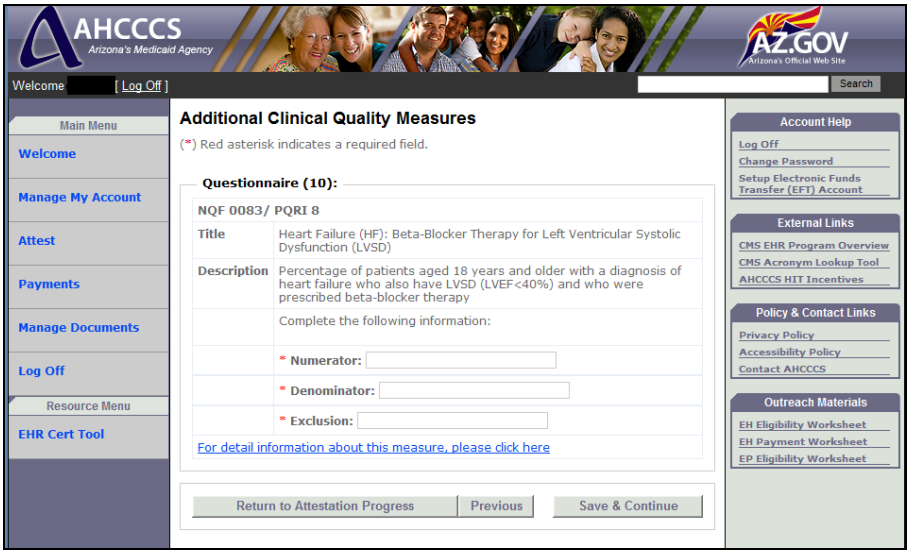
Additional Clinical Quality Measure 9



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

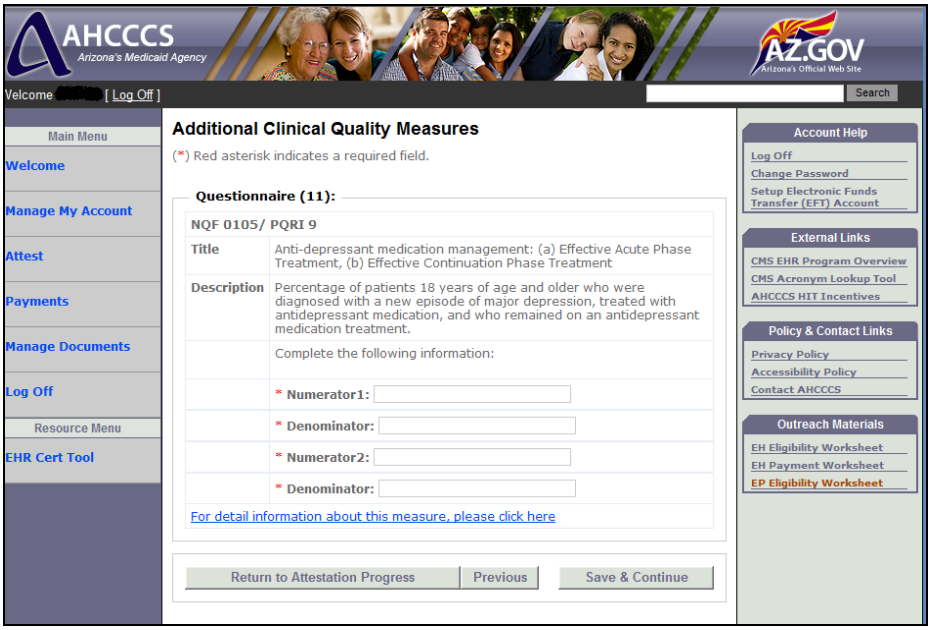
Additional Clinical Quality Measure 10



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

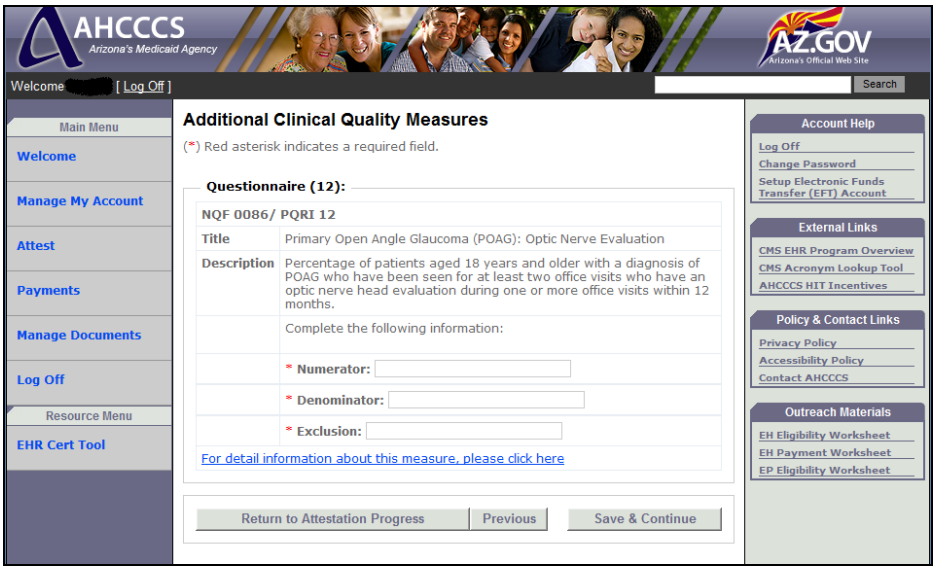
Additional Clinical Quality Measure 11



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

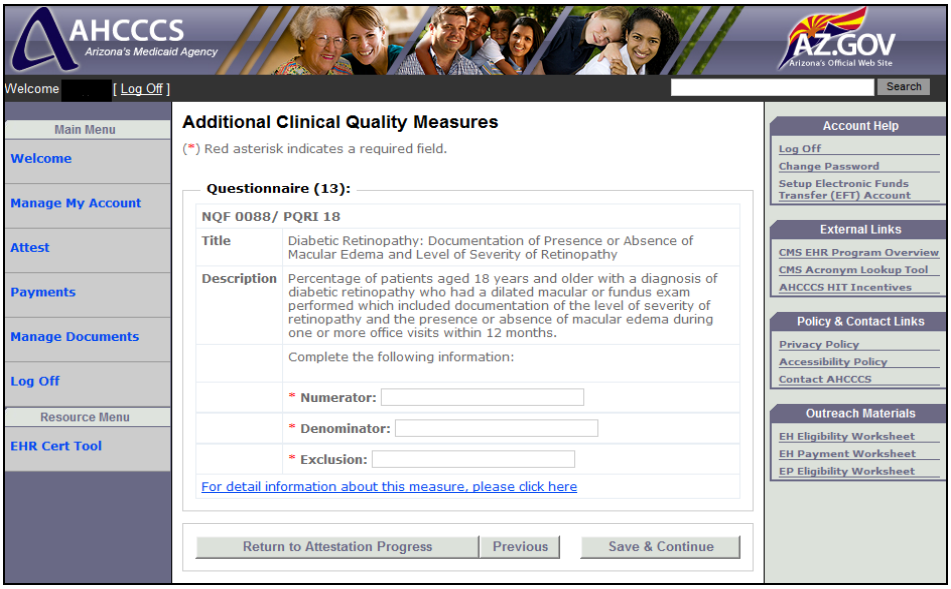
Additional Clinical Quality Measure 12



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

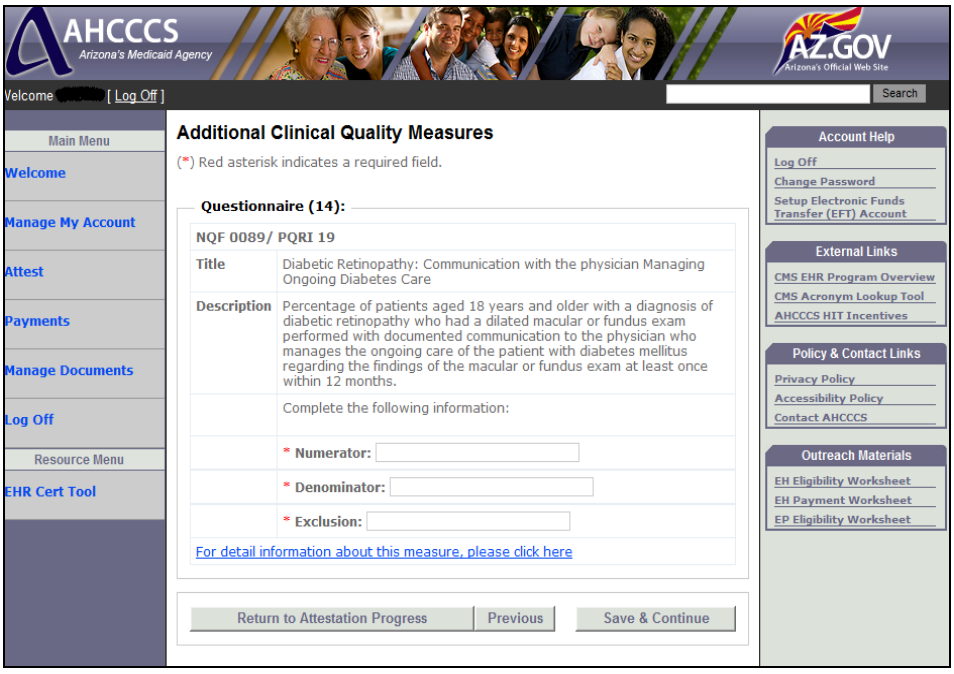
Additional Clinical Quality Measure 13



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

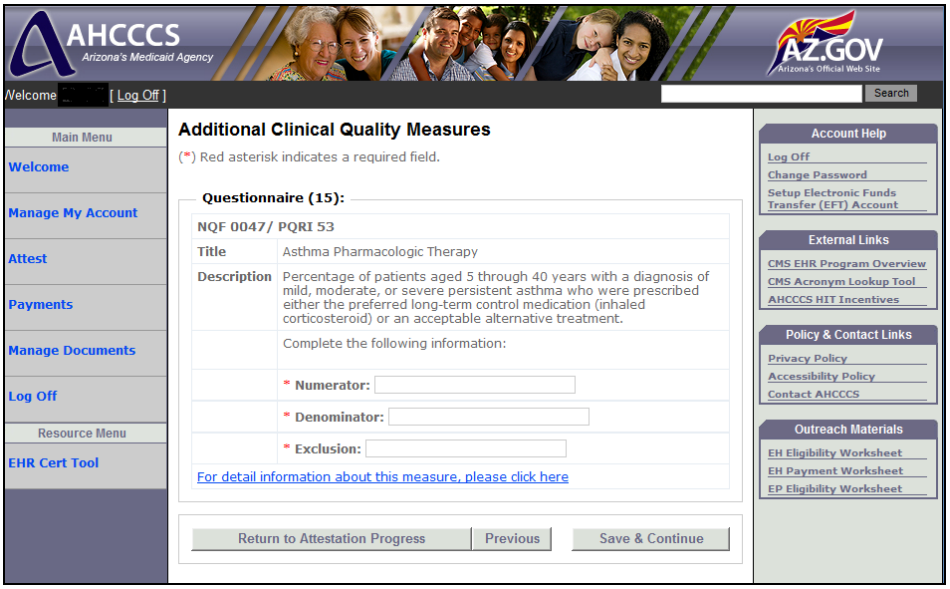
Additional Clinical Quality Measure 14



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

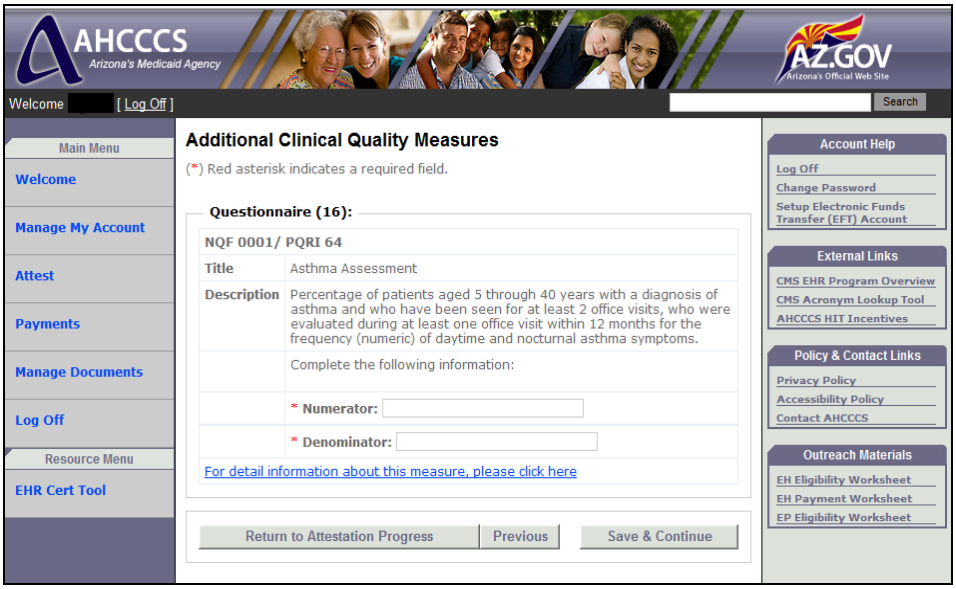
Additional Clinical Quality Measure 15



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

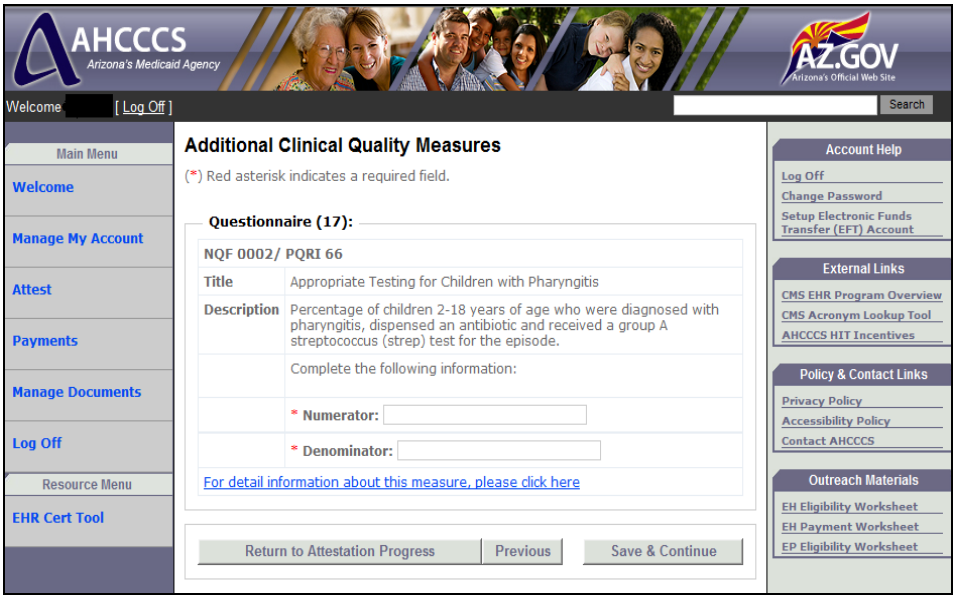
Additional Clinical Quality Measure 16



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

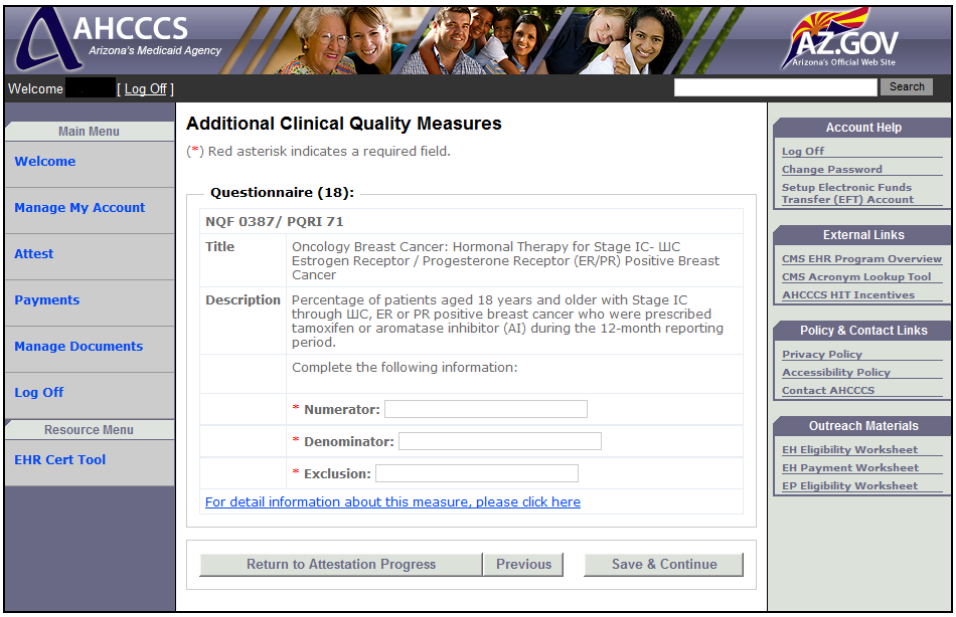
Additional Clinical Quality Measure 17



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

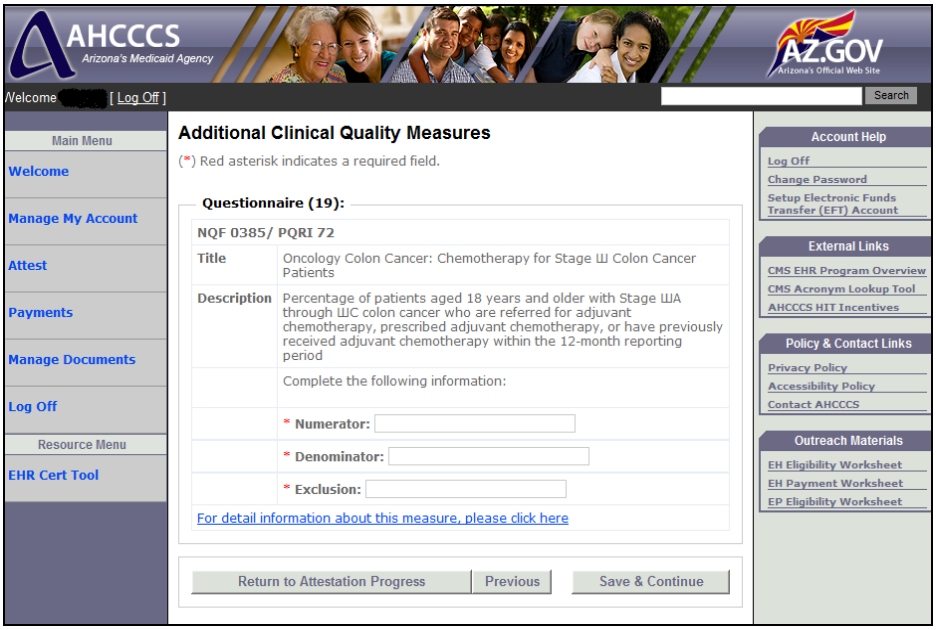
Additional Clinical Quality Measure 18



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

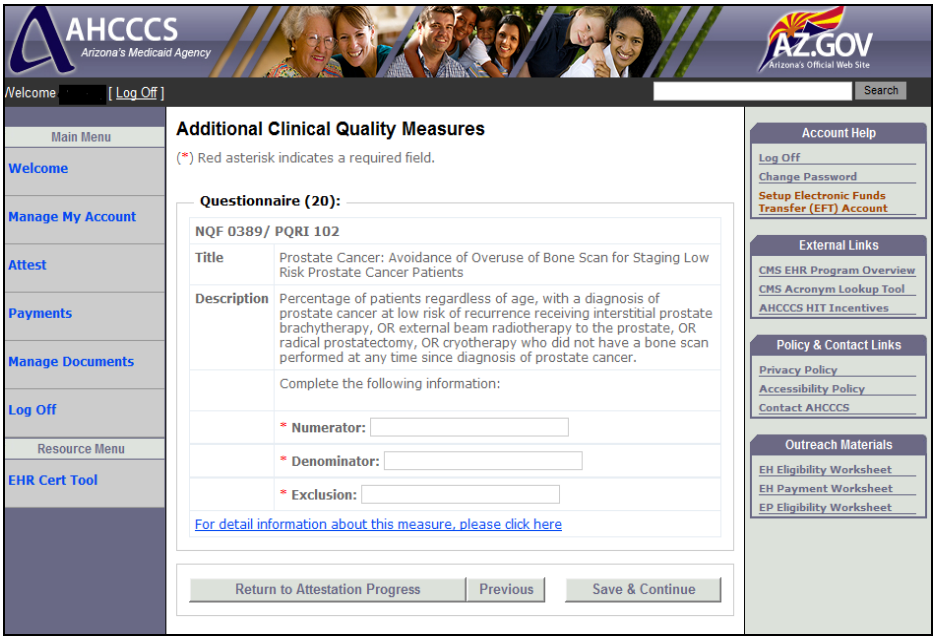
Additional Clinical Quality Measure 19



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

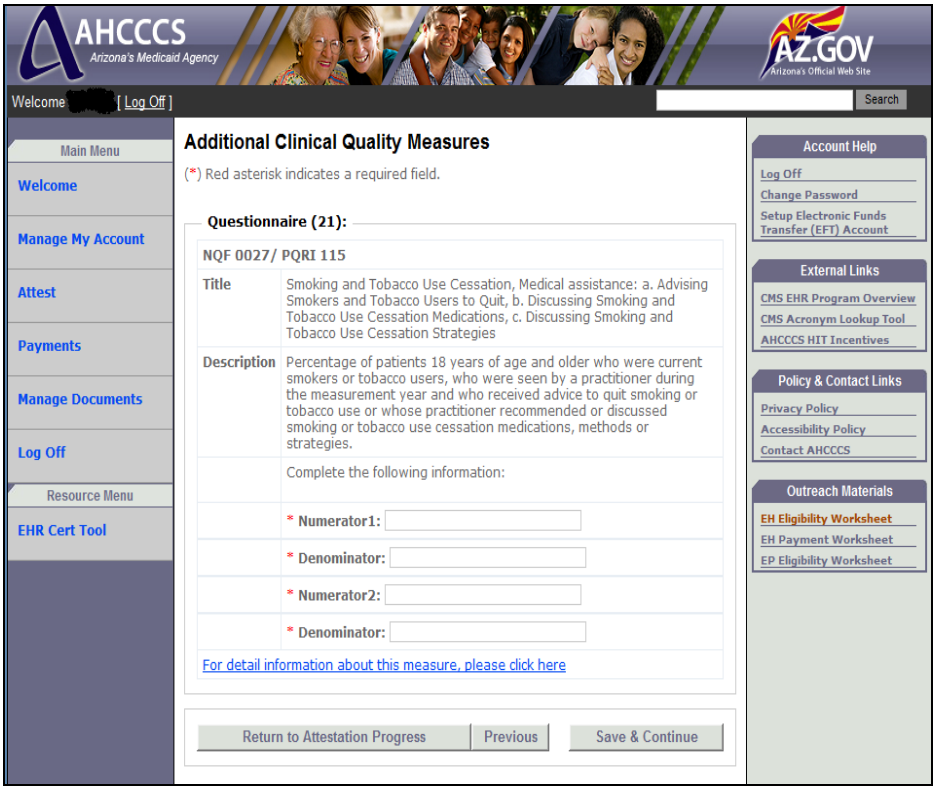
Additional Clinical Quality Measure 20



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

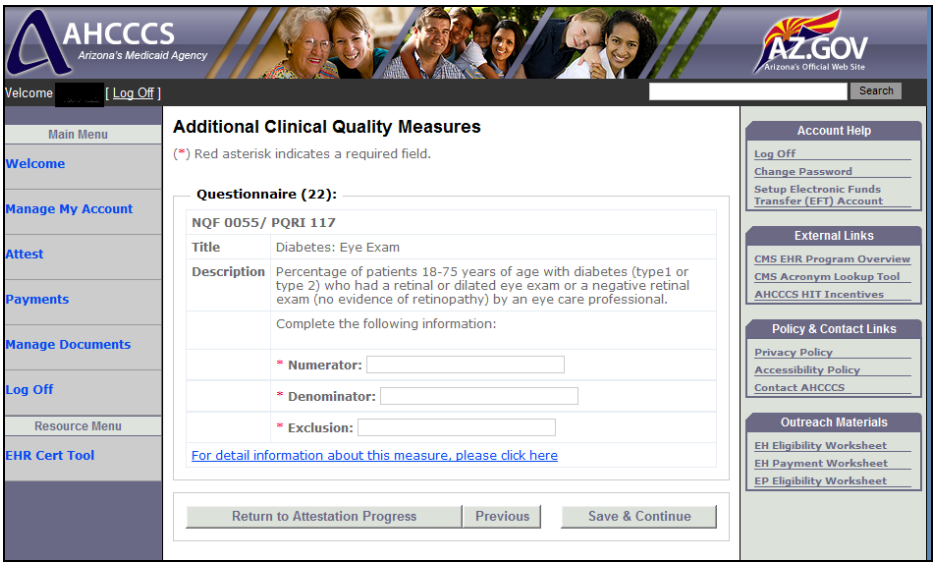
Additional Clinical Quality Measure 21



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

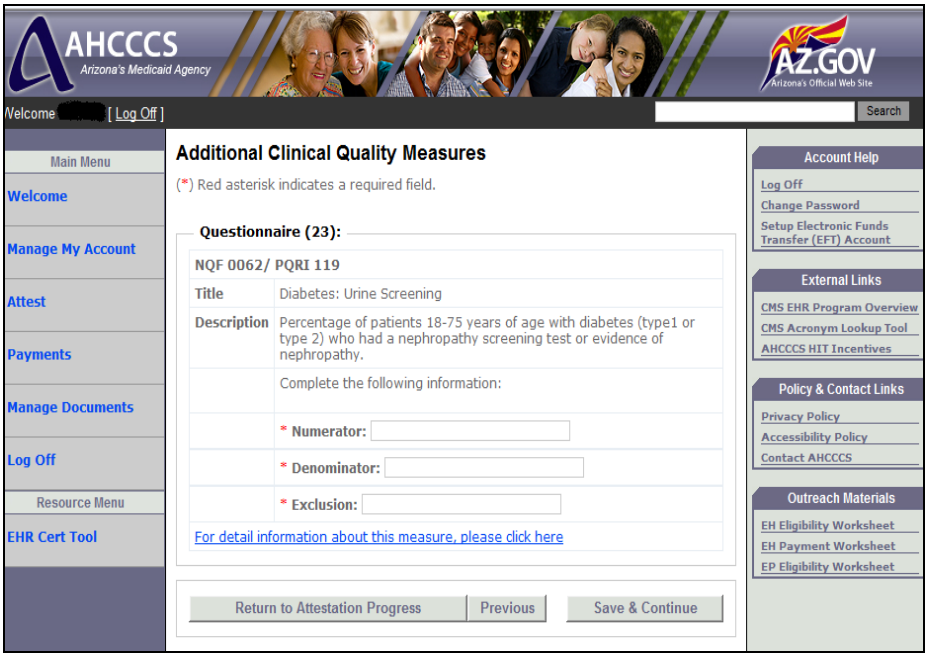
Additional Clinical Quality Measure 22



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

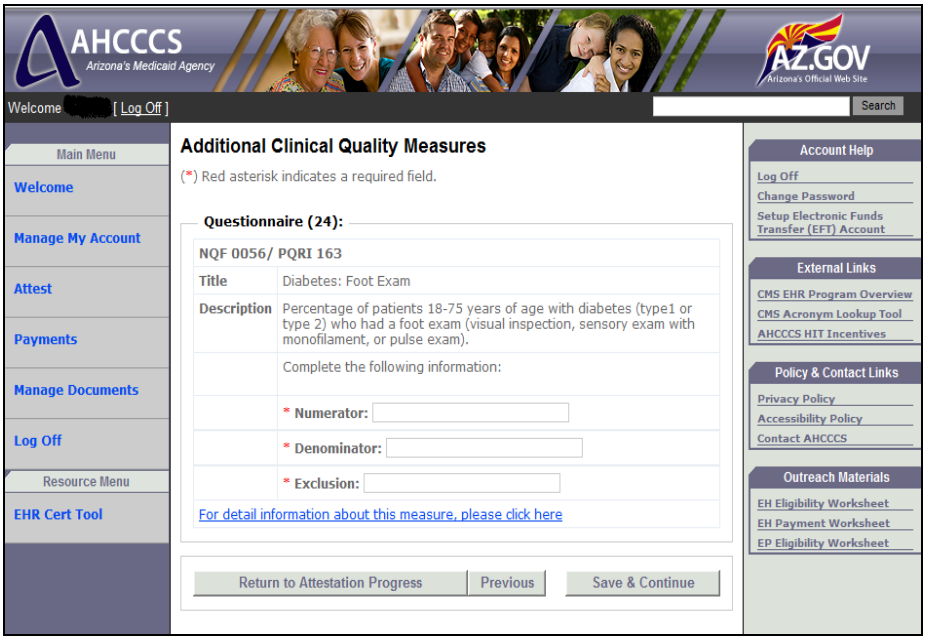
Additional Clinical Quality Measure 23



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

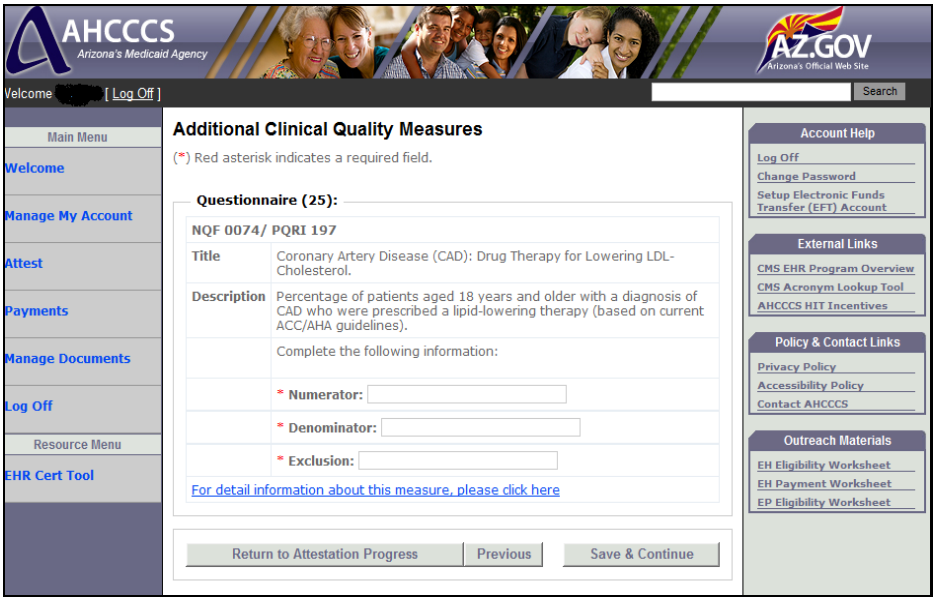
Additional Clinical Quality Measure 24



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

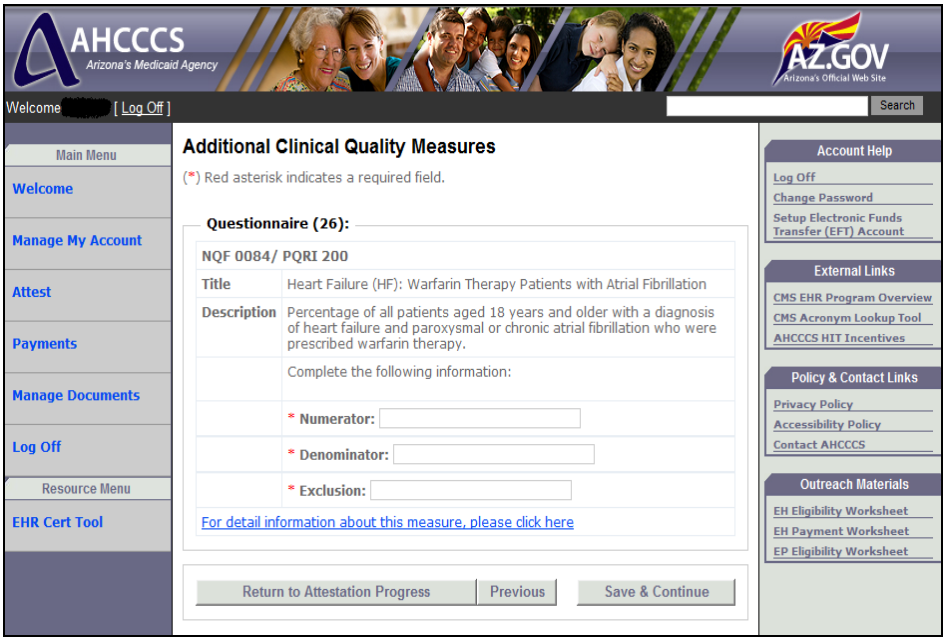
Additional Clinical Quality Measure 25



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

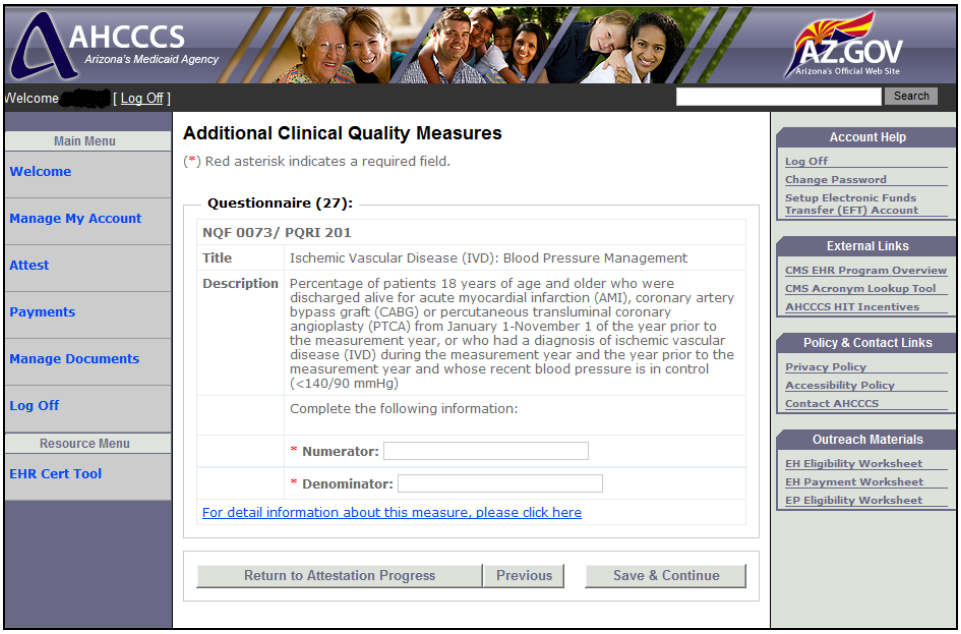
Meaningful Use Additional Clinical Quality Measure 26



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

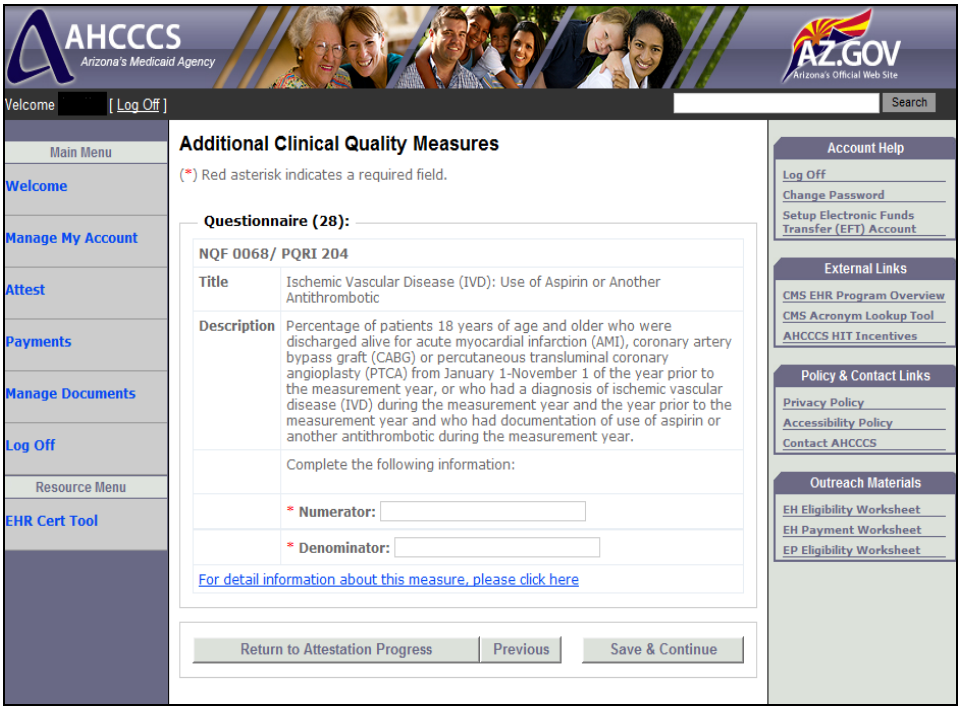
Additional Clinical Quality Measure 27: IVD - Blood Pressure Mgt.



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

Additional Clinical Quality Measure 28: IVD – Use of Aspirin or Another Antithrombotic

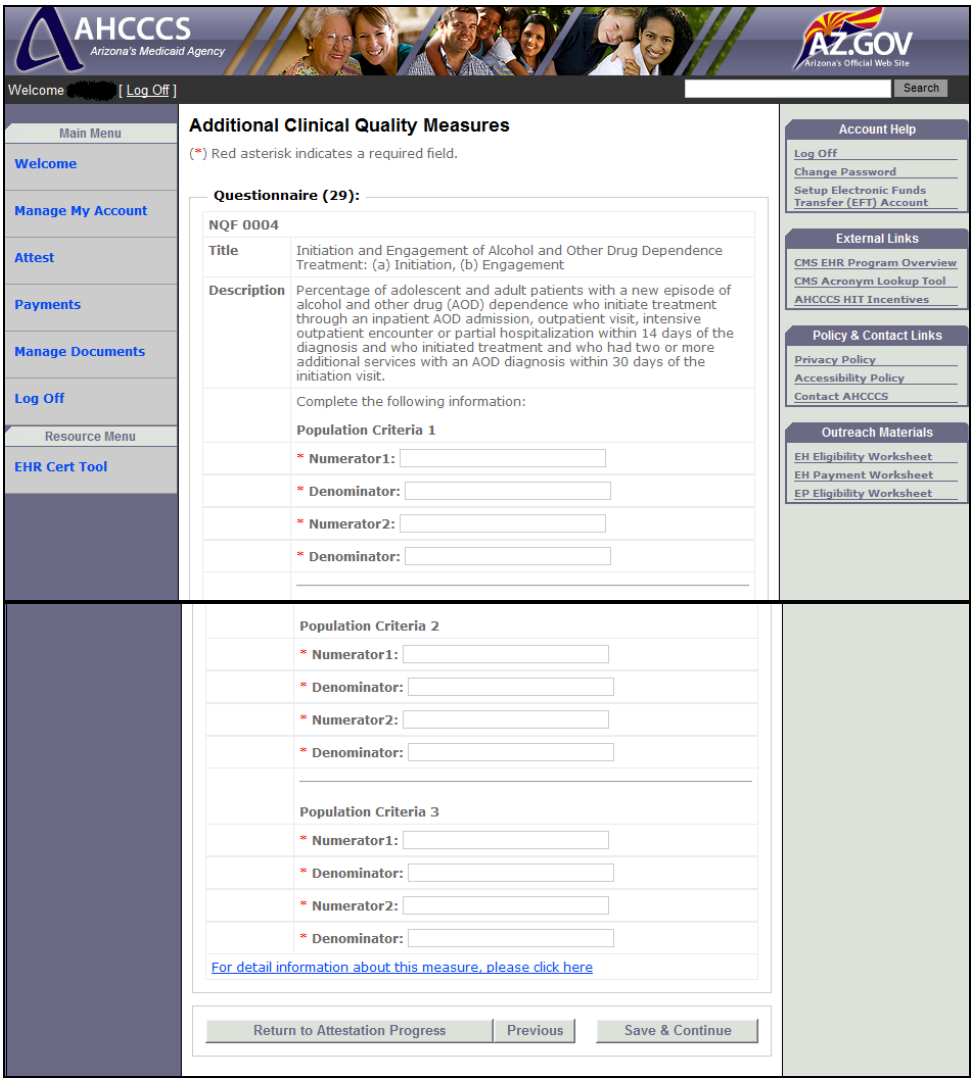


Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

Additional Clinical Quality Measure 29:

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

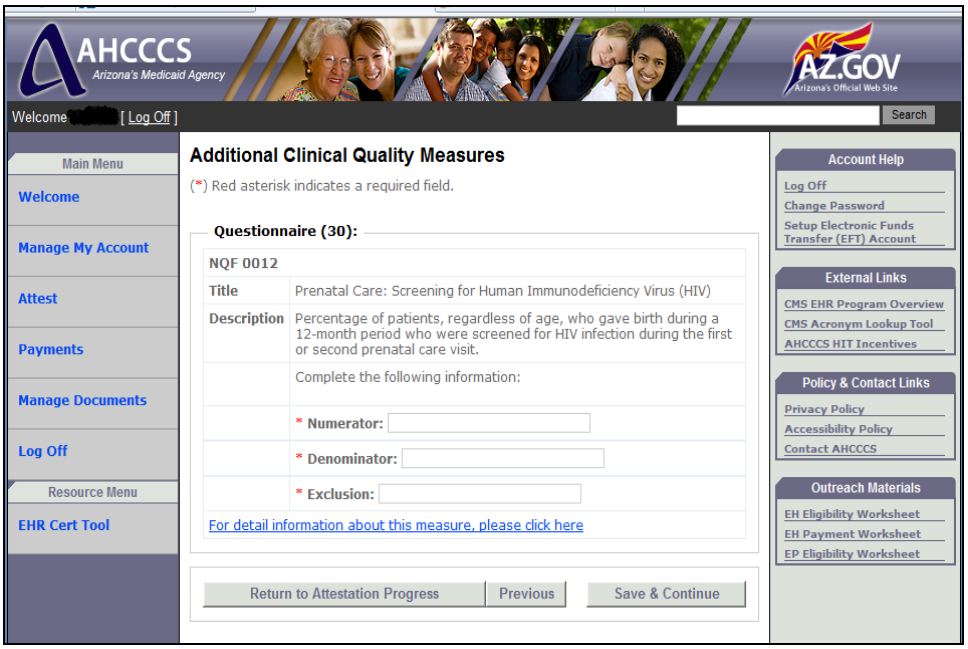


Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

Additional Clinical Quality Measure 30:

Prenatal Care: Screening for HIV

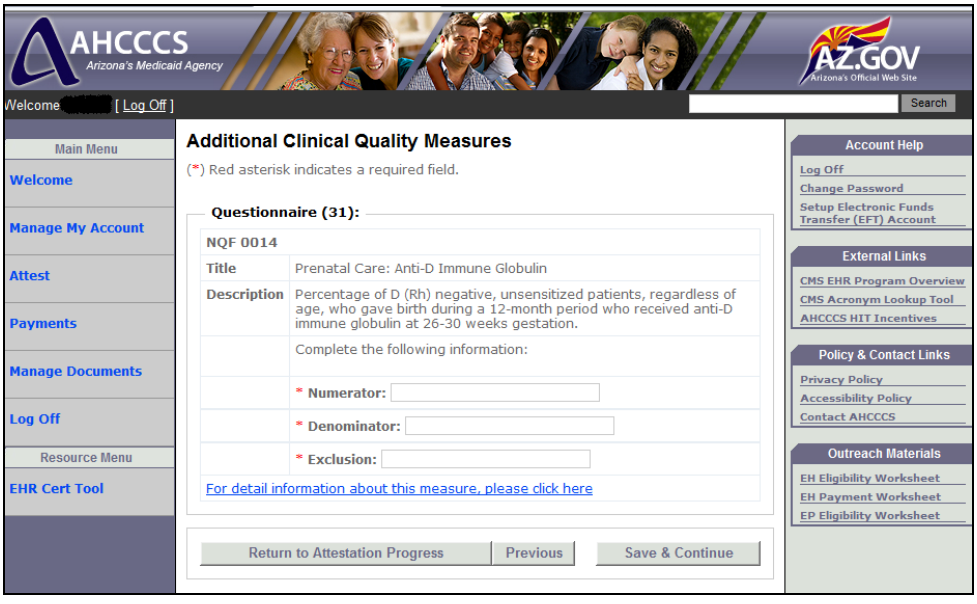


Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

Additional Clinical Quality Measure 31:

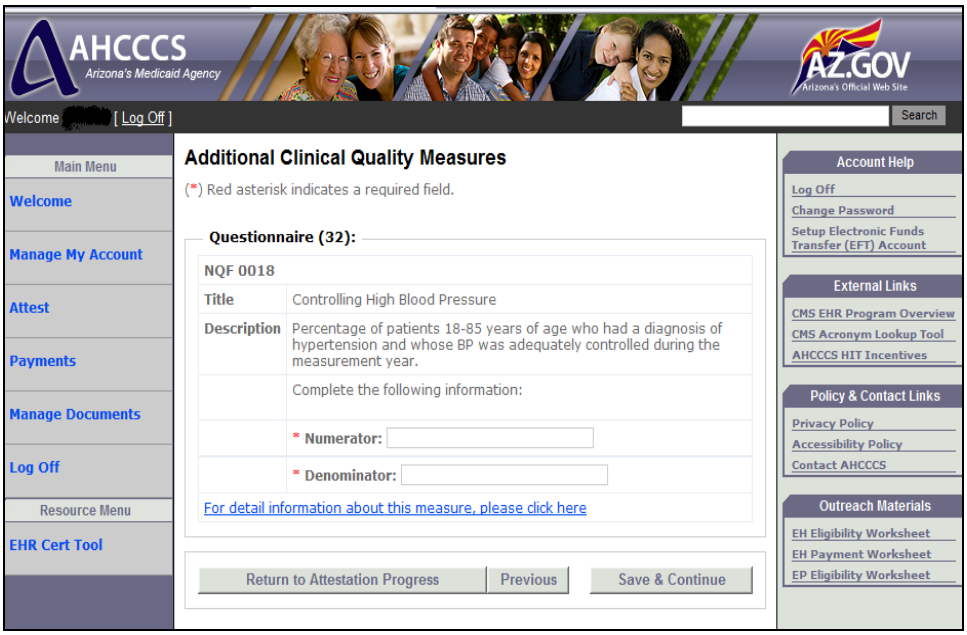
Prenatal Care: Anti-D Immune Globulin



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

Additional Clinical Quality Measure 32:
Controlling High Blood Pressure



Potential Error Messages:

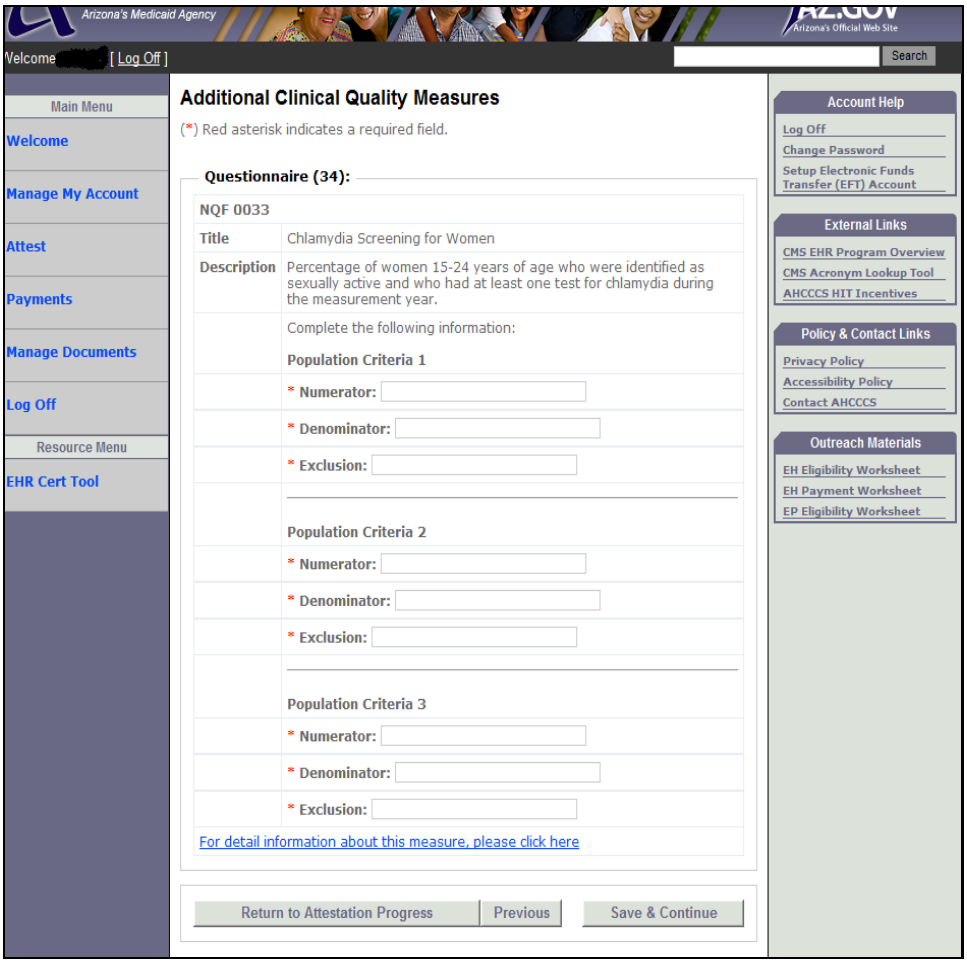
- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

Additional Clinical Quality Measure 33:
Cervical Cancer Screening

Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

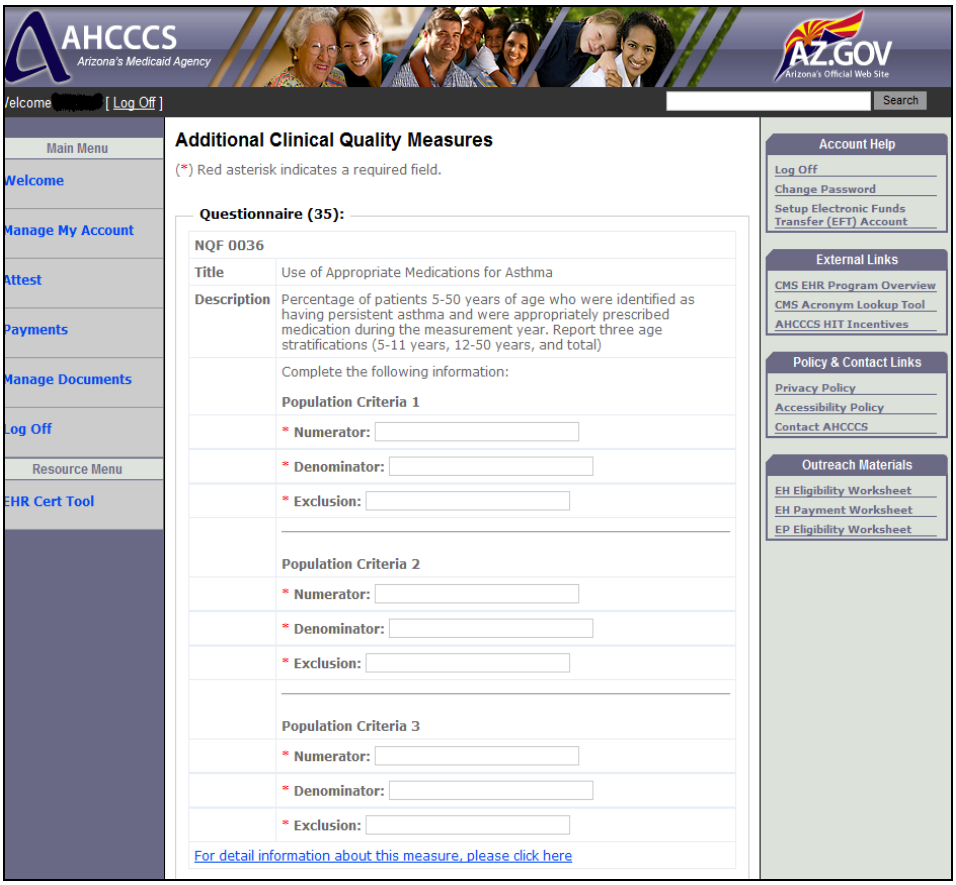
Additional Clinical Quality Measure 34:
Chlamydia Screening for Women



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

Additional Clinical Quality Measure 35:
Use of Appropriate Medications for Asthma

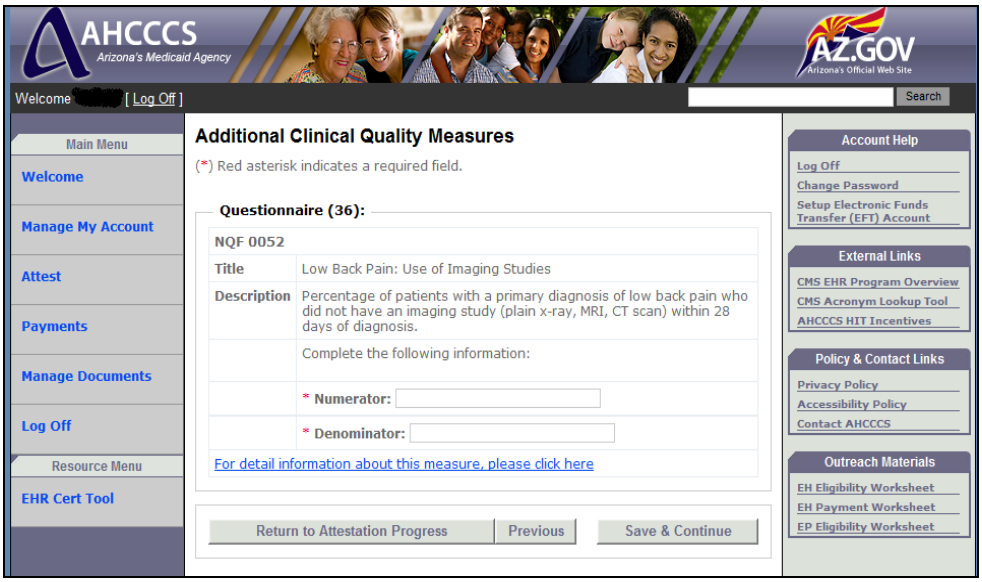


Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

Additional Clinical Quality Measure 36:

Low Back Pain: Use of Imaging Studies

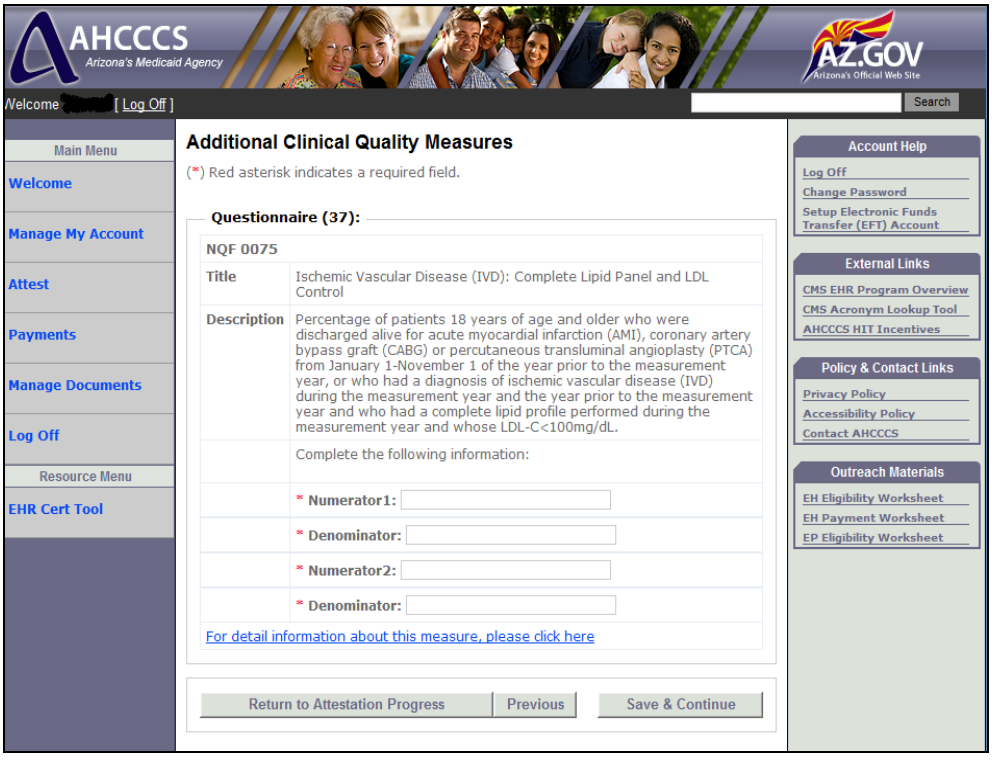


Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter a numerator that is equal to or less than the denominator.

Meaningful Use Additional Clinical Quality Measure 37:

IVD – Complete Lipid Panel and LDL Control

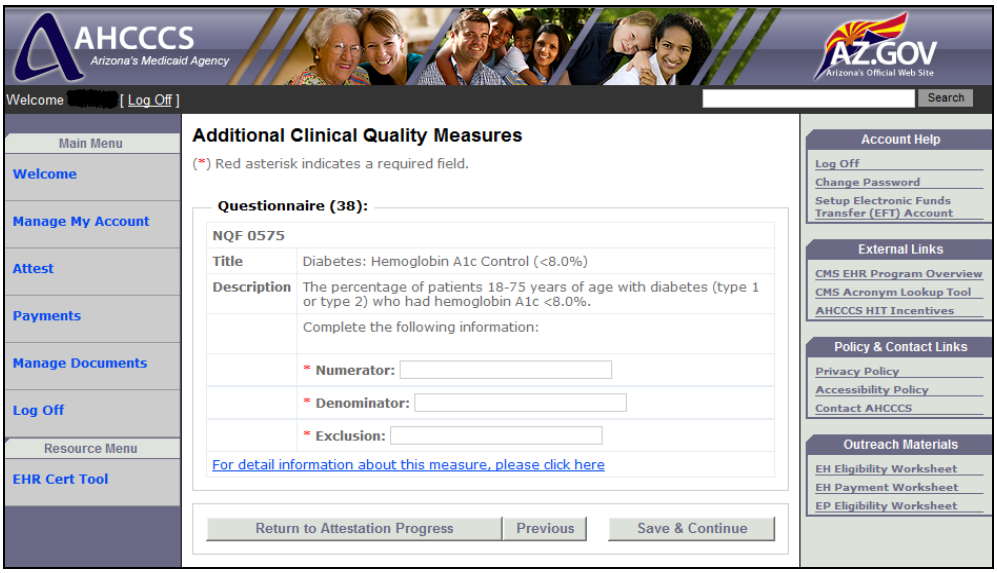


Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

Additional Clinical Quality Measure 38:

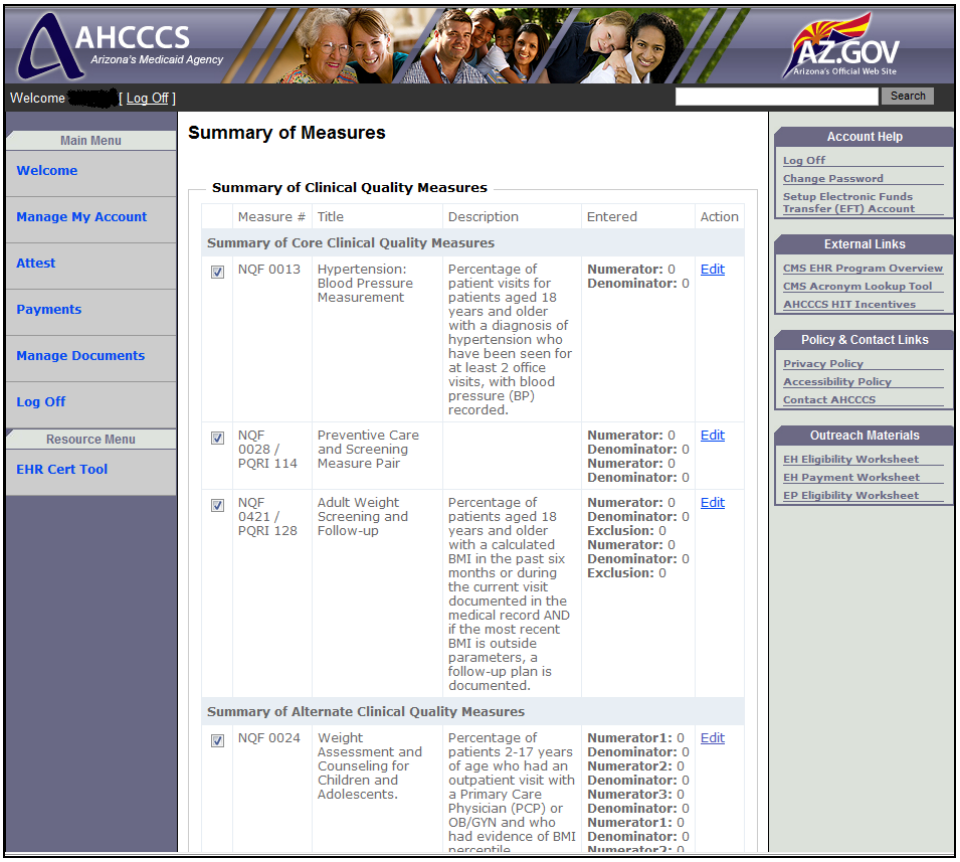
Diabetes: Hemoglobin A1c Control (<8.0%)



Potential Error Messages:

- Please enter a numerator.
- Please enter a denominator.
- Please enter exclusion data.
- Please enter a numerator or exclusion that is equal to or less than the denominator.

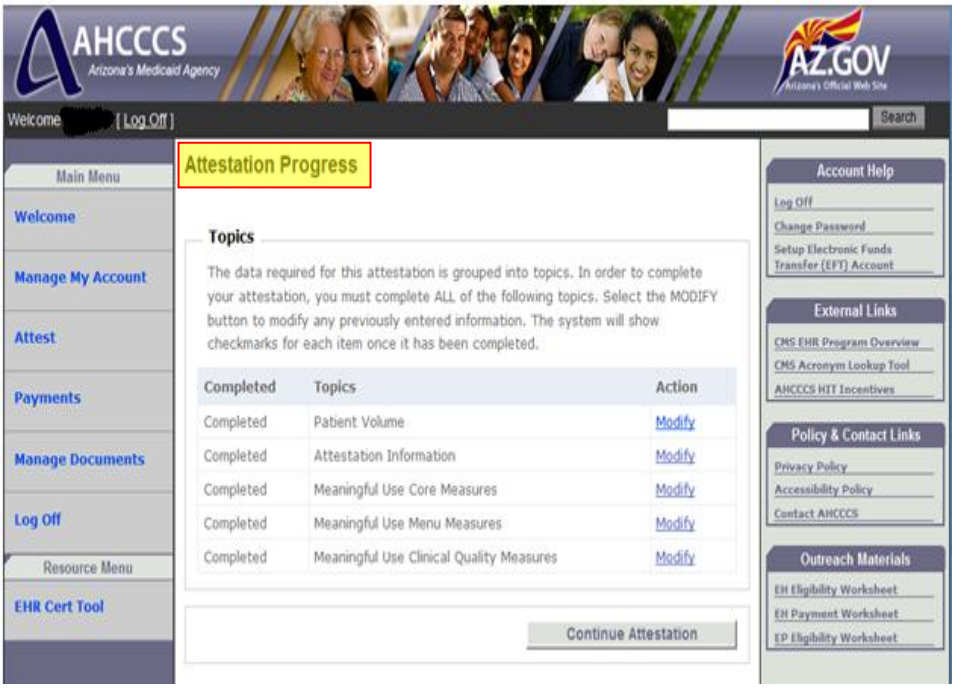
Meaningful Use Summary of Clinical Quality Measures



Note: This screen lists the Measure #, Title, Description, and Data entered by the EP for all the Clinical Quality Measures selected. EP's can click the **Edit** button by each measure summary to go to that measure and update the data entry.

Click **Return to Attestation Progress** to return to ***Attestation Progress*** page (see below).

Click **Continue** to go to ***Attestation Statement*** page.



Patient Volume Link –Takes the EP to Patient Volume page

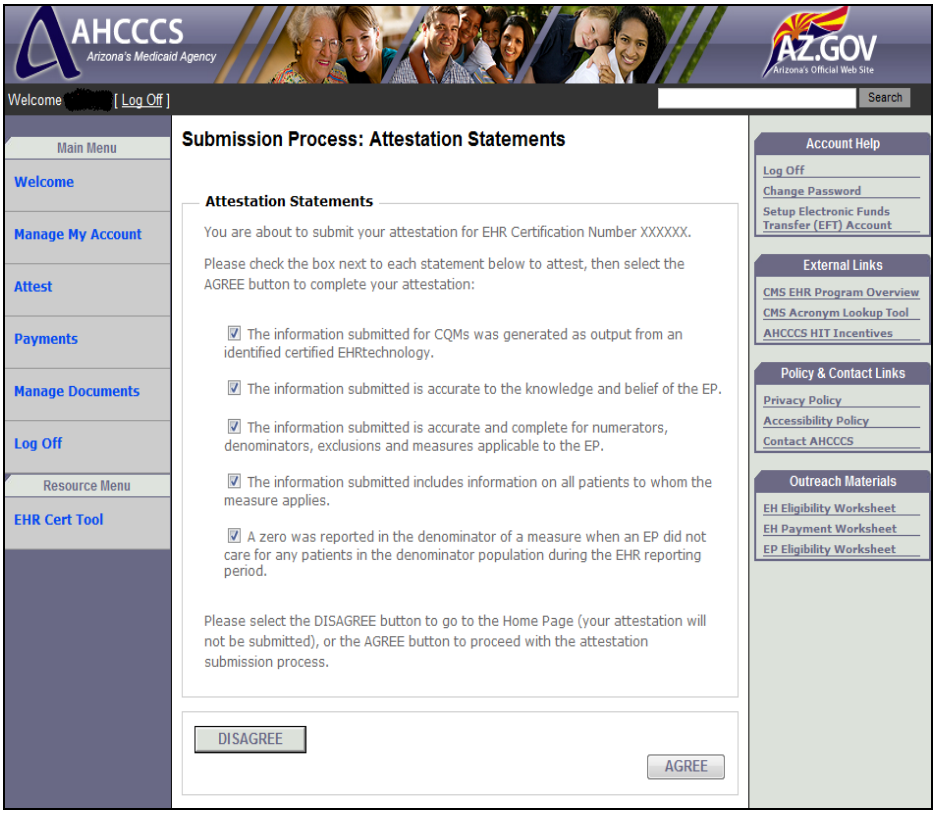
Attestation Information Link – Takes the EP to the Attestation Information page

Meaningful Use Core Measures Link – Takes the EP to the summary screen for Meaningful Use Core Measures

Meaningful Use Menu Measures Link - Takes the EP to the summary for Meaningful Use Menu Measures

Core Clinical Quality Measures Link – Takes the EP to the Summary of all Clinical Quality Measures

ATTESTATION STATEMENTS

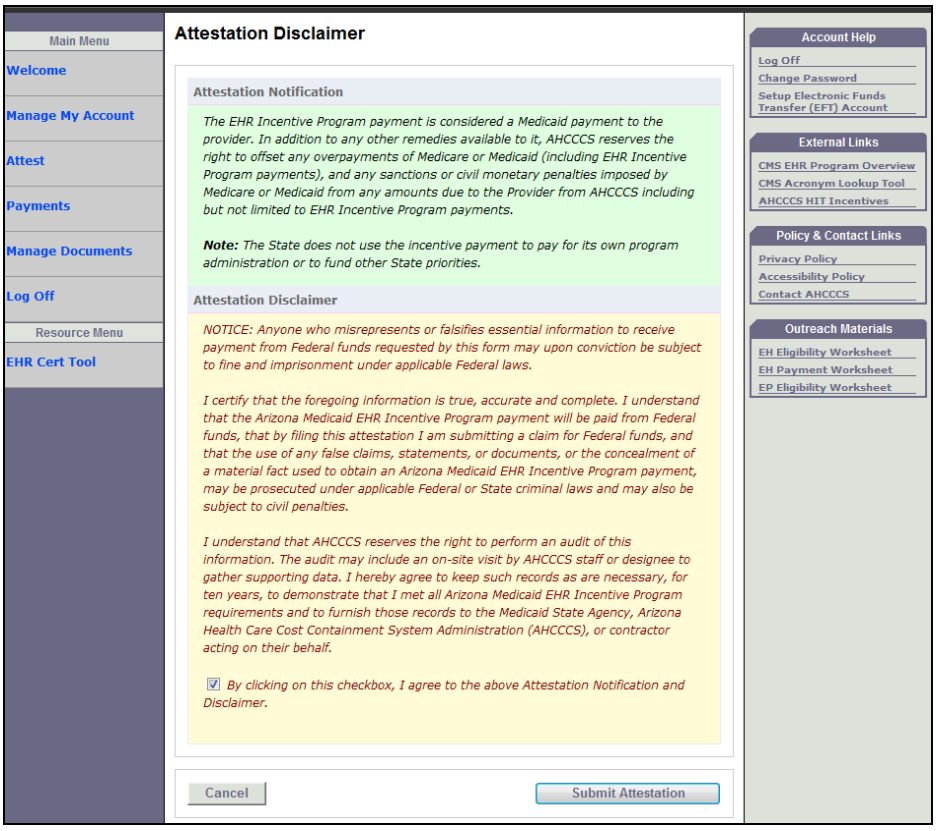


Note: The EP must check all the checkboxes in order to submit attestation.

Click "**AGREE"** to continue to Attestation Disclaimer page.

Click "**DISAGREE"** to go back to Attest page.

ATTESTATION DISCLAIMER

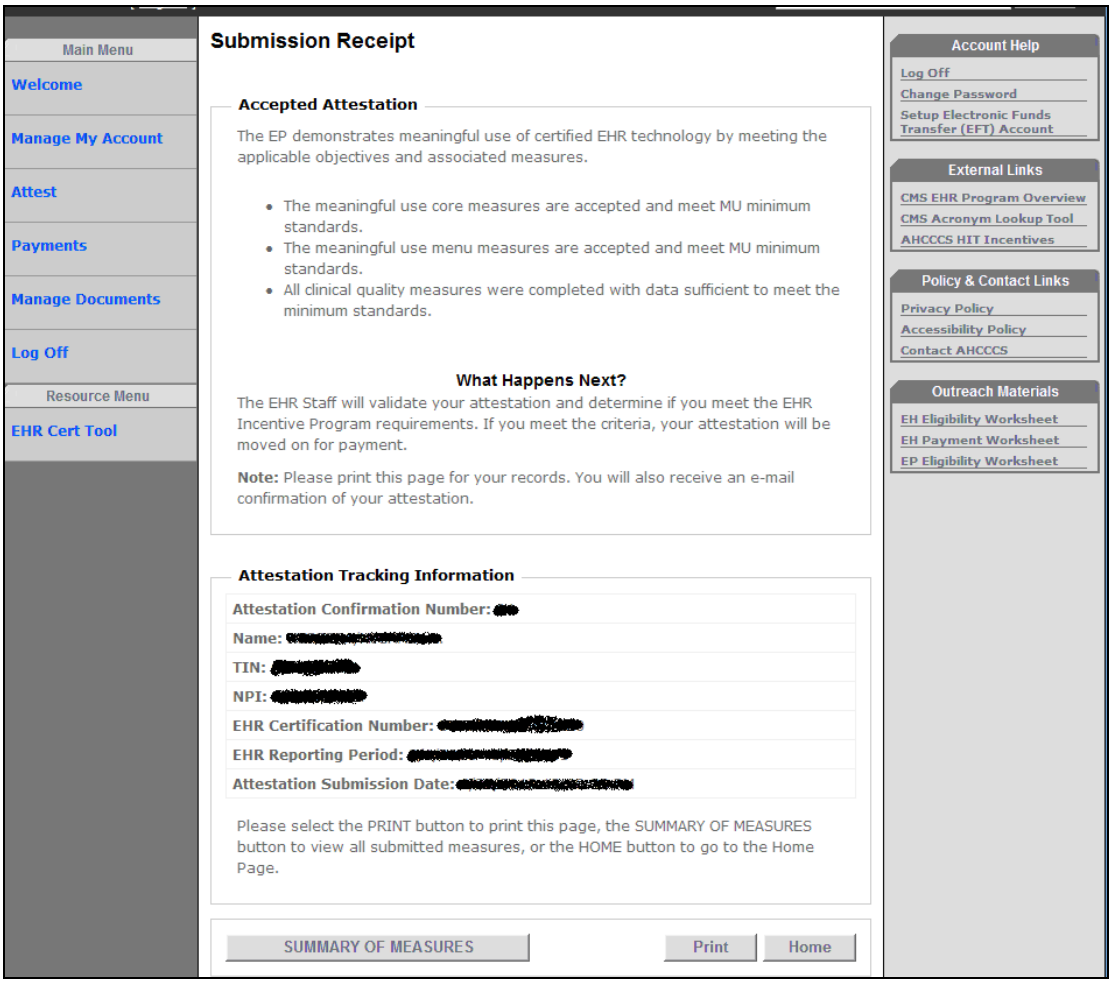


Note: Please read the disclaimer carefully. The checkbox MUST be checked to continue.

Click "**Submit Attestation**" to confirm submission.

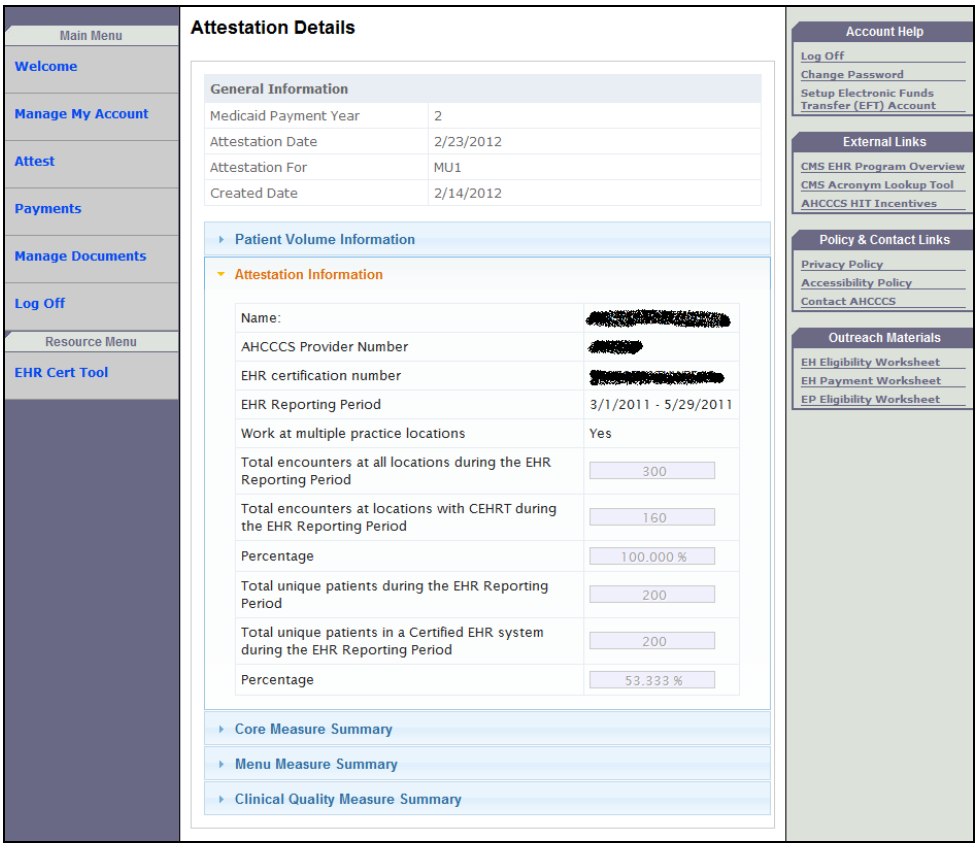
SUBMISSION RECEIPTS AND SUMMARY SCREENS

Submission Receipt (Accepted Attestation)



Note: Once the Attestation is submitted, the EP can view a submission receipt. Click "**SUMMARY OF MEASURES"** to view measure summaries for all measure entries. The attestation will be sent for internal review and determination of approval for payment. Click "**Print**" to print the Submission Receipt. Click "**Home**" to go to the home page.

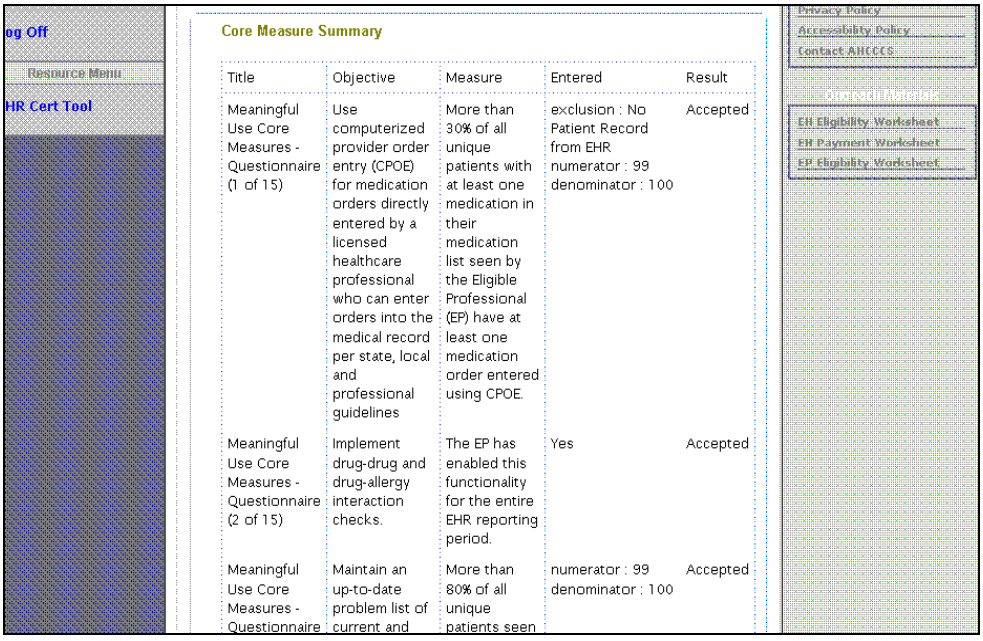
View Summary (Accepted Attestation)



NOTE: This is the Post Attestation summary. The EP can view summaries for Patient Volume, Meaningful Use General Information, and Meaningful Use Core, Menu, and Clinical Quality Measures.

The information viewed here cannot be edited. Please contact AHCCCS EHR Incentive Program staff if there is a problem with the information provided.

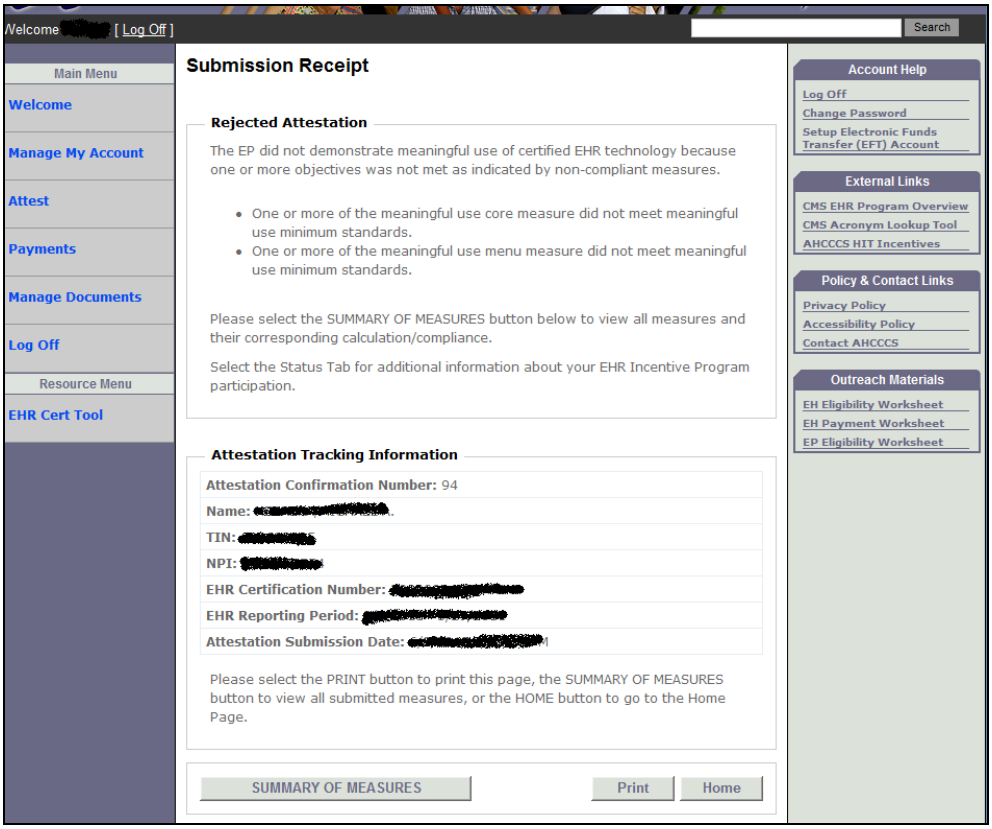
Example of a Core Measure Summary:



The summary of measures for the Core MU Measures contains columns for the following information:

- Title – gives measure title and number
- Objective – gives the objective of the measure
- Measure – gives the detailed measure information
- Entered – gives the data the EP entered
- Accepted/Rejected – indicates if the measure was Accepted or Rejected

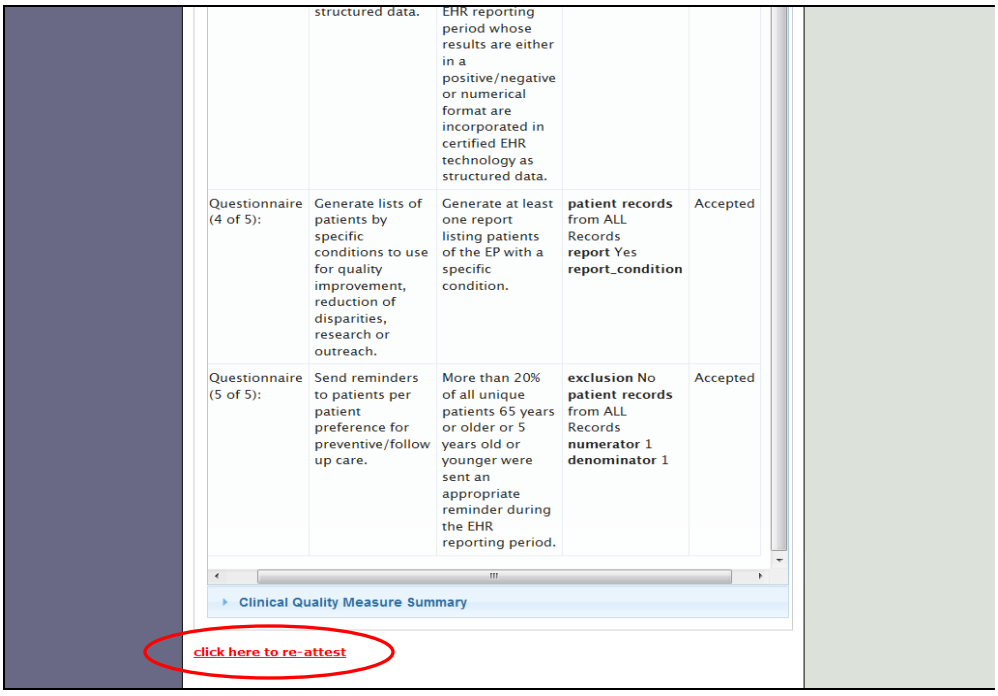
Submission Receipt (Rejected Attestation)



NOTE: If your attestation is not accepted you can review the summary of measures and look for the indication of which measure were not accepted.

The EP will be allowed to re-attest once the EP is able to meet the measure requirements. To re-attest, click the "**Summary of Measures"** button and review all of the measures. Then use the "Click here to Re-Attest" link at the bottom of the Summary page to re-attest. If you log out and come back to the system at a later date, you can re-attest by clicking "Attest" on the left sidebar once you have logged in to ePIP.

View summary (Rejected Attestation)



The summary of measures for the Core MU Measures contains columns for the following information:

- Title – gives measure title and number
- Objective – gives the objective of the measure
- Measure – gives the detailed measure information
- Entered – gives the data the EP entered
- Accepted/Rejected – indicates if the measure was Accepted or Rejected

APPENDIX A

AHCCCS – Arizona Health Care Cost Containment System

AIU – Adopt, Implement, or Upgrade are legal terms defined by federal law.

CHIP – Children's Health Insurance Program

CMS – Centers for Medicare and Medicaid Services

EHR – Electronic Health Record as defined by the Health Information Technology for Economic and Clinical Health Act (HITECH ACT)

EPIP: AHCCCS EHR Electronic Provider Incentive Payment System

FQHC/RHC – Federally Qualified Health Center/Rural Health Clinic

Hospital-Based - a professional furnishing ninety percent (90%) or more of their professional services in a hospital inpatient or Emergency Room setting (Place of Service Codes 21 and 23) and who is not eligible for a Medicaid HER Incentive Payment.

Medicaid Encounter for an Eligible Professional – services rendered to an individual on any one day where:

- Medicaid paid for part or all of the service; or
- Medicaid paid all or part of the individual's premiums, copayments, and cost-sharing.

MU– Meaningful Use

Needy Individual - Needy Individuals are those receiving Medical Assistance from Medicaid (Title XIX) or CHIP (Title XXI), individuals who are furnished uncompensated care by the provider, or individuals furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

NPI – National Provider Identifier is a ten digit number unique to each health care provider.

ONC – Office of the National Coordinator for Health Information Technology

Pediatrician – Pediatricians are physicians who treat and diagnose illness and injuries in children under the AHCCCS Medicaid program. As such, pediatricians must be an AHCCCS Provider who meets the physician scope of practice rules, hold a Doctor of Medicine or Doctor of Osteopathy degree, and hold a current license and board certified in Pediatrics.

Practice predominantly - an Eligible Professional for whom the clinical location for over 50 percent of his or her patient encounters over a period of 6 months in the prior year occur at a Federally Qualified Health Center or a Rural Health Clinic.

REC– Regional Extension Center

TIN – Tax Identification Number